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JANUARY 1973



Everybody experiences psychic tension.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page



A new round of Iowa lawmaking begins this month. The gavel will descend January 8 in both the Senate and House. We recognize this reapportioned 65th Assembly will have its unique problems and challenges.

The revamping of legislative districts to equalize population will at least initially frustrate many citizens and lawmakers as they seek to communicate with one another. This will pertain particularly in those instances where an individual is in a legislative district which has been changed markedly in its geographic make-up.

We are told, despite reapportionment, legislators from farms and small towns still outnumber their city associates. Fifty-four members of the House, a majority, are from farms and small towns; in the Senate, 24, one shy of half, are similarly located.

Rural legislators will represent city population in some instances. Mason City (population 30,491) is one example. It will be represented in the House by two farmers, one from a county neighboring Cerro Gordo, and in the Senate its legislative interests will be assumed by a farmer from south of the city.

The legislator who demonstrates the knack of being responsive to his constitutents in the restructured Assembly will rate our commendation. *This is my plea to Iowa physicians: Know your legislators, be helpful by providing information and by advising of your thinking on important issues.*

K. E. Lister, MD

K. E. Lister, President

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IOWA Medical Miscellany

NEW SESSION . . . The 65th Iowa General Assembly will open for business January 8. There'll be more Democrats, more young people, more labor representation, more teachers. Republicans will control both chambers, the House 56 to 44 (it was 63-37 last session) and the Senate 28 to 22 (it was 37-13 last time). The Senate will have 43 members with previous legislative experience; the House has 33 who've served before. The full delegation includes 37 incumbents, 11 former legislators and 52 freshmen. Despite reapportionment, lawmakers from farms and small towns outnumber their city colleagues.

HMO CONSIDERATION . . . Enabling legislation to permit health maintenance organizations to operate in Iowa will be key health measure before the 1973 Assembly. December meetings of the legislative study committee to study HMOs have served as a final prelude to consideration of actual legislation. Society legal counsel Robert B. Throckmorton met with the committee December 6 to reaffirm IMS preference for contractual arrangements with physicians. Throckmorton emphasized Society is not taking an obstructionist posture in the HMO consideration.

BLUE SHIELD UCR . . . Regular UCR claims handled by Blue Shield between July and October 1972 were paid in full or as submitted better than 95% of the time. Total charges in this period amounted to $2.7 million, over $2.6 million was paid. This does not include UCR business which has deductible or co-insurance provisions.

FAMILY PRACTICE . . . A discussion of potential for additional family practice residencies in Iowa occurred December 13 and involved representatives of College of Medicine, the Iowa Academy of Family Physicians, the Iowa Medical Society, plus physician representatives from existing FP residencies and from hospitals where FP residencies may be developed.

DECEMBER NEWS BULLETIN . . . Early December IMS News Bulletin summarized actions taken by AMA House of Delegates in Cincinnati. PSROs, HMOs, AMA finances, Medicredit, certificate of need legislation were among the items noted. Accompanying IMS News Bulletin was a one-page summary of new Professional Standards Review Organization (PSRO) requirements.

SURGICAL GUIDES . . . IMS Committee on Surgical Treatment of Obesity met in December to evaluate further the guidelines to be used in considering this type of surgery. The Committee was formed to serve in an advisory capacity to the State Department of Social Services and several interested insurance companies.

AMPAC STUDY . . . The American Medical Political Action Committee will support an in-depth analysis of the general election in Iowa. Study will be done by a private consulting firm.

CHP ACTION . . . The Comprehensive Health Planning Council approved in late November a statement calling for flexible, broad and innovative activity in development of health care plans in the state. Statement included support for the HMO approach but did not specify a particular means of providing physicians' services.

(Please turn to page 8)

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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JANUARY 1973

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The Question Box



by ELMER M. SMITH, M.D.

In this first presentation of THE QUESTION BOX feature, Elmer M. Smith, M.D., Director, Bureau of Medical Services, Iowa State Department of Social Services, responds briefly to several questions on Iowa Medicaid.

Approximately how many Iowans were served by Medicaid in 1972? How much federal-state spending was involved in providing this service?

Approximately 111,000 Iowans were eligible for Medicaid during the year ending July 1, 1972. About one-half of these recipients received services during a given month. Total payments to providers of service amounted to $24,756,066.78 for 1,029,792 claims. About 60% of the expenditure came from federal funds and the balance from the state appropriation. Physicians received 27.74% of the total expenditures. Average cost for those recipients receiving care through Title XIX amounted to approximately $35 per month.

What are the prospects for Iowa Medicaid in 1973?

The 1972 Social Security Amendments contain a number of provisions which will have an impact on Medicaid. Effective July 1, 1973, persons receiving Social Security disability payments will become eligible for Medicare. This will include many persons now receiving aid to the disabled and aid to the blind in Iowa who have also been covered under Medicaid. The fact that these persons will now be eligible for Medicare will result in a saving of funds under Medicaid, and this may make it possible for the Department to liberalize or expand the program in some other needed areas.

Are there any modifications pending which will affect physicians?

As most Iowa physicians know, during the last six months, the Department has been implementing its program of early and periodic screening, diagnosis and treatment of children under age six in aid to dependent children (ADC) families. Effective July 1, 1973, federal regulations require extension of this program to all ADC children under age 21. This will affect physicians inasmuch as many children who may not previously have seen a physician will be referred by the County Department of Social Services to local physicians for screening. In this connection, we should point out the Department is working with the Iowa State Department of Health, State Services for Crippled Children and other agencies capable of providing screening services to be supportive in localities of the state where physicians are in short supply.

As of January 1, 1973, the Department implemented its Intermediate Care Facilities Program. In this program care in licensed nursing homes (not skilled nursing homes) will be covered under Title XIX and payment for services provided will be made by the carrier directly to the facility. Although this represents a major change in Medicaid we do not anticipate it will have any great effect on participating physicians.

Are there any things Iowa physicians can do to make the Medicaid program run more smoothly?

Periodically the carrier sends participating physicians Informational Letters and revisions

in the Medicaid Handbook for Physicians. These outline changes in the program which apply to physicians' services. We urge all physicians and appropriate office staff members to read these releases thoroughly. This will improve the smoothness and efficiency of the program and will eliminate misunderstandings concerning program coverage. Too, it will reduce situations which result in extensive correspondence between the carrier and the physician, incorrect payments and delay in payments. In this connection we would point out that physician cooperation has generally been excellent since the inception of Medicaid.

How does Iowa rank alongside other states in the effectiveness of its Medicaid program?

It is difficult to compare because states vary widely in such areas as eligibility, type and amount of medical care covered, use of a carrier, etc. Iowa's program is essentially comprehensive in terms of type and amount of medical and health services covered. Since this is not the case in some states, to that extent Iowa's program is more effective than that in those states. On the other hand, due to the lack of funds, our program covers only individuals and families who are receiving public assistance. Some states include one or more groups of the "medically indigent," so in that realm it must be said those programs are more effective than ours. In terms of administration, it is our understanding from the Regional Office of the Department of Health, Education and Welfare that Iowa's program is being administered at least as well as any other in this four-state region and in a number of areas it is better.

IOWA MEDICAL MISCELLANY

(Continued from page 5)

LICENSING BOARDS . . . Proposals emanating from Professional and Occupational Licensing Interim Study Committee of the General Assembly urge appointment of "consumers" to various licensing boards. The Committee is also advocating continuing education in some form as a requirement for licensure renewal. Under study are licensure practices of more than 20 professions and occupations. Abolishment of the Basic Science Board is one recommendation scheduled for referral to the 1973 Assembly.

GROUP INSURANCE . . . IMS Group Insurance Committee has requested Blue Cross/Blue Shield to evaluate carefully present Statewide Physicians Program and recommend alternatives for upgrading it. Particular concern is over the limited mental health coverage now available. Committee has asked for a report this month.

RE-APPOINTED . . . Clarence H. Denser, Jr., M.D., Des Moines, has been re-appointed to the Committee on Quackery of the American Medical Association.

LAB FOR INFANTS . . . A cardiovascular laboratory for children and infants will be built at The University of Iowa. The one-story addition to west wing of The U. of I. General Hospital will have four examination offices, a heart catheterization diagnostic unit, exercise laboratory, chemistry laboratory and facilities for sonic and electronic charting of heart sounds.

BECOMES EFFECTIVE . . . New Iowa State Department of Environmental Quality becomes operative this month as a result of legislation passed in 1972. The Department will have responsibility for air quality, water quality, solid waste management and chemical control programs. The Department becomes responsible for a radiation program which is to regulate the storage, handling and disposal of radioactive materials.

MEDICAID PATIENT REVIEW . . . Letters from Department of Social Services will advise Iowa physicians when one or more patients in intermediate care facilities will be subjected to medical review as required under Public Law 92-223. Reviews are intended to assure Title XIX recipients are receiving proper care from the nursing home in accordance with the physician's written orders.

State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

EMERGENCY MEDICAL SERVICE COMMUNICATIONS IN IOWA

The December 1972 issue of the JOURNAL summarized the progress made with Emergency Medical Service in the past year. EMS Advisory Council and the EMS Communications System Task Force of the Council were mentioned. This article will describe in more detail the communications facet of EMS.

To establish an economical and capable statewide communications system, the CS Task Force first recognized the need to evaluate various technical, medical, legal and political problems. The Task Force has engaged a communications systems consultant (Spectra Associates, Inc. of Cedar Rapids, Iowa) to assist in this. The consultant, working with the CS Task Force, has surveyed the EMS communications systems in Iowa. Deficiencies in the present EMS communications system have been identified and a plan for improving the system is being developed. When complete, the plan is for use by local, regional and state EMS planning groups to upgrade emergency services.

A primary objective of the total effort will be to reduce the time between receipt of a request for emergency ambulance service and delivery of the patient to the hospital with appropriate emergency facilities for the particular problem. The EMS communication system must provide (1) for public reporting of service requests to an emergency center, (2) for communication between the center and the ambulance dispatch, and (3) for communication between ambulance technicians and hospital emergency room personnel. Communication between the ambulance team and law enforcement personnel is also required.

Emergency Medical Service Communications in Iowa today may be summarized as follows:

1. Private citizens initiate more than 40% of the emergency requests for ambulance service. These requests come through various channels which differ from one community to another. Requests are directed to telephone operators, to police or fire departments, or to ambulance services. A few fortunate communities have a single emergency request telephone number which is publicized by private and public agencies.

2. An experimental highway emergency reporting system (HELP) is being tested by the Iowa Highway Patrol. It is for use particularly on the interstate and primary highways. The statewide emergency number, 800-362-2200, transfers calls to Post 1 Headquarters in Des Moines, where a dispatcher will summon aid from a community near the emergency.

3. Over half the communities with EMS radio communications use local police, fire, or sheriff's radio dispatch facilities. The radio equipment used in ambulances is generally loaned to these municipal and county organizations.

4. Presently, 16% of Iowa's hospitals have two-way radio communication with ambulances bringing patients to their emergency departments.

5. 80% of Iowa's hospitals can be notified a patient is enroute to their facility. 93% of the hospitals want to be notified of a patient delivery.

6. Generally, hospital administrators and ambulance service managers recognize the need

for direct communication between ambulances and hospitals within their regions. Only 24 Iowa communities now provide for EMS radio communication between ambulances and hospitals.

Examination of the present system points up several deficiencies:

1. Citizens are often not well informed about how to request emergency service. This causes delay which results in suffering and needless fatalities.

2. Multiple requests for ambulance service result in unneeded emergency vehicles at the accident location.

FOR MORBIDITY REPORT SEE PAGE 32

3. EMS communications are not always given the appropriate priority.

4. There is inadequate hospital-to-ambulance communication in most communities. This limits the transfer of important patient information between ambulance attendants and doctors. This is also true during patient transfer from a community hospital to a major medical center.

5. Only a few hospitals have two-way, 24-hour radio communications with ambulances.

While these deficiencies must be overcome, it should be recognized the EMS communications system has developed to its present point out of strong community spirit. Various voluntary and cooperative arrangements are a part of the present system.

The EMS communications system will provide the best emergency services when it meets the following requirements:

1. Assures effective local and regional planning through highly motivated community leaders.

2. Allows effective statewide cooperation between local and regional personnel to provide communication and mutual assistance in event of a major emergency.

3. Provides EMS communications centers for receipt of urgent requests and control of emergency vehicle dispatch.

4. Enables an EMS dispatcher to get necessary emergency vehicles and qualified personnel to the scene without delay.

5. Allows patient information transfer between emergency vehicle and receiving hospital while patient is enroute.

6. Allows hospital emergency personnel and ambulance personnel to confer with physician specialists when needed.

7. Enables communications between public safety personnel and emergency medical personnel.

8. Provides an economical extension of present EMS communications which can be easily expanded with the growth of community medical services.

A draft of the Emergency Medical Service Communication System Plan is now being reviewed by the EMS Advisory Council and the Communications Task Force. The Plan recommendations should be available soon so those involved in emergency medical services may review them and determine what action they want to take. The Communications Task Force will provide assistance in this process.

I REMEMBER WHEN—DO YOU?

In the early days lack of prenatal care (people were not educated for this) resulted in eclampsia and frequent pre-eclamptic conditions. The eclamptic seizures were something to behold. They were terrifying not only to relatives, but also to doctors. The treatment of some at that time was the Caesarean Section. My training with Dr. Letzenberg was of a conservative medical nature with emphasis on reducing the edema. In one case, I refused to do a Caesarean even though the referring physician wanted it done. After that I never once had an obstetrical referral from this physician; in fact no cases at all. Present students hardly ever see a case of eclampsia and treatment results are good.

The prevention of eclampsia and the low incidence of pre-eclampsia have occurred because of prenatal care and the attention given to research on the physiological aspects of the condition. This is another example of progress in medicine in the last 50 years and one which is not due to the advent of antibiotics or sulfas.—OTTO N. GLESNE, M.D., *Chairman,* IMS Historical Committee

SCIENTIFIC ARTICLES

Discoid Menisci

PETER D. WIRTZ, M.D.
Des Moines

Discoid menisci are a relatively rare cause of internal derangement of the knee. Smillie found 29 cases out of 1,300 menisectomies.[5] The lateral meniscus has been found to be discoid in all but one of the reported cases. The rarity of this condition often causes it to be overlooked. This paper reports briefly the typical history, the physical findings and gives a case report of a bilateral lateral discoid menisci.

The first description of this entity was by Young in 1889 from a dissecting room specimen.[6] Since then, many authors have described similar findings in dissections as well as operative specimens.[2, 3, 4, 5]

The "snapping" knee of the newborn has often been thought of as a subluxation of the knee joint[4] or a "snapping" of a ligament or a tendon over a bony prominence. In reality, this "snapping" is due to the incongruous movement of the femur riding over the meniscus on the tibia. The discoid meniscus is thicker than the normal meniscus, and as the knee extends, the meniscus bulges in front of the femur until approximately 20 to 25 degrees short of full extension. At this point, the femur rides up over this ridge on the meniscus and causes the "snapping" or "clicking." A similar mechanical problem occurs with flexion, in that near full flexion the femur again rides up over the meniscus. This ridging, as well as the increased thickness of the meniscus, makes this type of meniscus more prone to tears, as evidenced by nearly one-half of these menisci being torn at surgical removal.[4]

The "snapping" knee has been described as a "thudding," "clicking," or a "clunking" sensation. This snapping is painless and joint tenderness, muscle wasting, or synovial effusion are usually not present.[4] If there is a traumatic tear, then typical findings usually occur.

Etiology of such a meniscus is debatable. The fetal precursor has been thought to be a solid fibrocartilaginous structure.[1] Theoretically, there is a failure of resorption of the central portion of the meniscus.[2] Comparative anatomy studies have failed to reveal such a meniscus, therefore Kaplan believes this etiology is unlikely.[3] His human embryology studies have failed to demonstrate a discoid meniscus at any time during development. He believes partial absence of the posterior attachments (tibial portion) allows more mobility of the meniscus which causes an irritative or hypertrophy process to occur, and this fills in the central portion.[3]

Regardless of the cause, this condition is

Dr. Wirtz is in the private practice of orthopaedic surgery in Des Moines.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY, 1973.

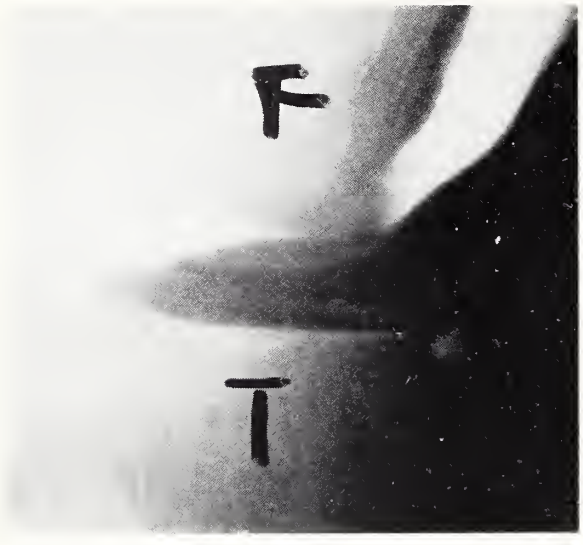


Figure 1. Left knee arthrography showing the lateral discoid meniscus as the radiolucent area between the femoral and tibial articular cartilage.



Figure 2. Right knee arthrography showing the lateral discoid meniscus with a tear.

usually painless and does not require removal if there has been no significant injury to the meniscus.

CASE REPORT

F. L. is a 38 year old white male paratrooper. There is no familial history of knee abnormalities. In 1962, the right knee sustained a twisting injury during a military air-lift maneuver. The resulting swelling had no early treatment and he experienced periodic effusions which were related to increased activities. After this initial episode, he noted painless snapping of the right knee with forced flexion.

In February of 1972, while fishing, his left knee was forcibly flexed and he noted a snap. Following this, he felt like something stopped extension of the knee. Examination of the left knee revealed full motion without effusion. An incongruous movement near full extension caused a snap, but not with full flexion.

Examination of the right knee revealed full motion without effusion. A painless snap was noted only with full flexion.

Arthrography of both knees revealed typical findings as illustrated (See Figures 1 and 2), the right showing a meniscal tear.

Surgical removal revealed the illustrated specimens (See Figures 3 and 4), each with a



Figure 3. Left lateral meniscus with two tears.



Figure 4. Right lateral meniscus with a tear.

tear. Postoperative recovery was uneventful, but such a postoperative condition eliminated him from air-lift maneuvers, which he readily accepted.

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Facial Pain: A Neurological Perspective

RICHARD A. CALKINS, M.D.
Iowa City

FACIAL PAIN is often a perplexing problem. It can for practical purposes be categorized as neuralgia, atypical neuralgia and symptomatic neuralgia secondary to intracranial and extracranial disorders.[1]

TRIGEMINAL NEURALGIA

Trigeminal neuralgia, or tic douloureux, is characterized by paroxysms of severe, darting, electric-like pain in the distribution of the branches of the trigeminal nerves, most often the maxillary division, frequently the mandibular division, and rarely the ophthalmic division. The cause is unknown.[2] Commonly, an attack can be provoked by stimulating a "trigger zone." Frequent sites are the alveolar ridges, near the lip at the corner of the mouth, or around a nostril. The trigger zone is not always in the same division as the location of the pain, and blocking one trigger zone may allow the identification of a second in another division. Trifling stimuli such as a draft of air, washing the face, applying cosmetics, talking or chewing may stimulate the trigger zone and provoke an attack of pain. Eating may be impossible. The pain may spread to an adjacent division but does not cross the midline, although one to three per cent of sufferers will eventually have tic douloureux on the other side of the face.[3] Attacks usually abate at night; the patient may sleep comfortably. The elderly are more often afflicted. Guarding and splinting to prevent pain may result in tension headache; the location of this pain may confuse the examiner. Associated depression may be misleading. Diphenylhydantoin, carbemazepine, alcohol blocks, peripheral neurectomy and retro-Gasserian neurectomy comprise modern therapy. The medical treatment has been summarized by Rushton.[4]

ATYPICAL FACIAL NEURALGIA

Characteristic features[5] are the gradual onset over a period of minutes or hours; persistence for hours, days or weeks; location deep in the soft tissues or bones rather than superficially; and distribution within the area of supply of the major vascular channels rather than the area of a nerve branch. A common location is over the malar eminence, from which the pain may extend to the homolateral temple, posterolateral neck, shoulder and arm. The pain is described as aching, boring, drawing or as a sensation of pressure, sometimes associated with a stabbing component. Frequently, there is a spread of pain to adjacent areas or across the midline. There is no trigger zone, but the pain may be aggravated by lying down, straining or jolting. Nausea, vomiting, dizziness, asthenia and chilling sensations may be associated. Nasal stuffiness, rhinorrhea, conjunctival injection and facial flushing are also common. Anxious younger patients with a neurotic disposition are frequently afflicted, and a personality type characterized by com-

Dr. Calkins was an assistant professor in the Department of Neurology and the Neurosensory Center at The University of Iowa College of Medicine. The Center is supported by Program-Project Grant No. N503354 of the National Institute of Neurological Diseases and Stroke, Bethesda, Maryland. Dr. Calkins is now a clinical associate professor of medicine at Michigan State University and is in private practice in Lansing, Michigan.

pulsivity and difficulty in handling hostile feelings is commonly observed. An attack may follow an emotional upset. The pathophysiology of atypical facial neuralgia has been a subject of debate for many years,[6] but there is reason to consider the disorder related to migraine.[5, 6] Ergotamine is the most effective agent in treatment, often enhanced by antihistaminics; psychotherapy may be the most profitable therapeutic endeavor. Sphenopalatine ganglioneurectomy cannot be recommended.[8] Enthusiasm for methysergide[9] may be overzealous.

SECONDARY (SYMPTOMATIC) TRIGEMINAL NEURALGIA INTRACRANIAL DISORDERS

Structural disorders may result in pain in the face when the trigeminal nerve, its ganglion (Gasserian), or its central connections are encroached upon by some pathological process. Of 57 patients with tic douloureux Abbott and Killiffer[10] found 8.7% to have mass lesions. Furthermore, pathological processes implicating the upper cervical radicals may result in pain in the distribution of the ophthalmic branch of the trigeminal nerve for the descending spinal nucleus of the trigeminal nerve extends to the upper cervical region.[11, 12] Cervical disc disease[13] and other lesions of the cervical canal may cause face pain.

Carotid artery aneurysms,[14] persistent trigeminal artery,[15] sphenoid wing meningiomas, temporal lobe tumors, granulomas and pituitary adenomas[16] have all been reported to cause trigeminal neuralgia presumably by pressure directly on the Gasserian ganglion, perhaps by compromising its blood supply. Mehta *et al*[17] recently added cholesteatoma of Meckel's cave while Fortuna and Gambacorta[18] reported a cylindroma to involve the Gasserian ganglion. Cylindroma and other nasopharyngeal malignancies presumably extend from their origin in the nasopharynx through foramina at the base of the skull to involve the Gasserian ganglion or branches of the trigeminal nerve. Meningeal metastases or direct invasion by other malignancies may present in the same way.[19] Concomitant paralysis of ocular rotators is an important clue in diagnosis.

Isolated trigeminal neuropathy has been reviewed.[20] Occasionally, the trigeminal nerve is involved in diabetes mellitus,[21] solitary neurofibroma,[14, 22] traumatic dental extraction or accidental injury.[21] In the latter two conditions an amputation neuroma may be found. Postherpetic neuralgia occurs in 10% of patients who have suffered ophthalmic zoster;[23] face pain ascribed to zoster without skin lesions has been confirmed serologically.[24]

Paratrigeminal neuralgia, or Raeder's syndrome, is characterized by pain in the region supplied by the ophthalmic branch of the trigeminal nerve associated with ptosis and miosis on the same side due to sympathetic paralysis.[25] Arteritis of the supraclinoid portion of the carotid artery, trauma, carotid artery aneurysm, meningioma of the sphenoid wing and migraine have been mentioned as possible causes. The superior orbital fissure syndrome of Rochon-Duvigneaud[26] is characterized by pain in a similar distribution associated with ocular rotatory palsies. A low grade inflammatory process is the likely mechanism. Inflammatory disease in and about the cavernous sinus, the syndrome of Talosa-Hunt[27] is similar. Steroids may be beneficial in these disorders.

The secondary pathways of the trigeminal nerve in the brain stem may be involved by a plaque of multiple sclerosis[28] or intrinsic pontine glioma, vascular malformation or other mass lesions.[10] Tic douloureux in young adults may suggest multiple sclerosis, but Rushton and Olafson[29] regarded this association a coincidence.

The finding of neurologic deficits in the appropriate distribution often betrays the lesion which masquerades as idiopathic trigeminal neuralgia. However, secondary (symptomatic) tic douloureux is not always associated with demonstrable neurologic deficit.[10]

EXTRACRANIAL DISORDERS

Systemic Disease: Occasionally pain due to coronary artery insufficiency may spread to the face. The atypical location and paroxysms of pain will understandably mislead the unwary; a trial of nitroglycerine during an attack may be a useful diagnostic test. Pre-auricular, dental, face or jaw pain has been reported to be a cardinal manifestation of subacute thyroiditis, a disorder more common in women.[30] Temporal arteritis may be manifest by jaw pain, particularly when chewing.

Local Disorders: Patients are quick to ascribe pain in the face to presumed maladies of their eyes, paranasal sinuses or teeth. Ocular

muscle imbalance and errors of refraction rarely cause facial pain.[31] Glaucoma should be kept in mind. Chronic sinusitis does not as frequently cause face pain as is reasoned by the patient; acute sinusitis should be considered if temperature elevation, leucocytosis, nasal congestion and discharge, and tearing accompany pain in the face. Acute ethmoidal or sphenoidal sinusitis produce pain behind the eye, at the glabella, or at the medial canthus of the eye. Pain over the sinus with tenderness to percussion just under the supraorbital ridge indicates acute frontal sinusitis. Tenderness to percussion over the canine fossa, just deep to the nasolabial fold, with pain over the maxilla is indicative of acute maxillary sinusitis. When the signs and symptoms of acute inflammation of the paranasal sinuses are accompanied by epistaxis, malignancy should be suspected.

The teeth more than any other structure are regarded by patients to be the source of face pain; and perhaps rightly so for many physicians would agree.[32] Nearly every patient with a difficult problem of face pain has asked his dentist to extract a tooth he regarded the offender. A careful search should be made for foreign bodies, e.g. a tooth brush bristle.[33] In the elderly, unerupted molars may be painful.[34] Pulpitis,[35] caries, apical abscesses,[36] retained fragments,[37] or defective restitutions are other causes of face pain. A piece of ice wrapped in gauze can be applied to each tooth until the sensitive tooth is identified by reproduction of the pain. There should be a specific reason for dental extraction lest repeated attempts to alleviate suffering result in a dental cripple. Malocclusion with disorder of articulation at the temporomandibular joint is probably an infrequent cause of pain located superficial to that joint; most cases of so-called Costen's syndrome[38] are probably due to other disorders.

APPROACH TO THE PATIENT

The evaluation should begin with a careful, unhurried history, keeping in mind that the patient is apt to describe his symptoms in terms of migraine, neuralgia, toothache or sinusitis for these are problems with which he is familiar.[39] Patients react differently to pain; younger patients tolerate pain poorly while the elderly, fearing malignancy, withhold information. Considerable trouble can be expected in eliciting a description of the pain. The patient should be asked to characterize the pain with respect to onset, duration, type, location, severity, precipitating factors and response to previous treatment. Assessment of the patient's mental status should be made, realizing that aberrations may be due to severe pain. General physical examination should be conducted with the examiner particularly mindful of systemic diseases. During the neurological examination special effort should be made to determine changes in corneal sensitivity and sensitivity in the distribution of the branches of the trigeminal nerve, weakness or wasting of the masseter muscles or weakness of the pterygoid muscles.

Special diagnostic laboratory tests which may be helpful include roentgenograms of the head, neck, sinuses and teeth, electrocardiogram, glucose tolerance test, thyroid function tests, erythrocyte sedimentation rate, and serological tests for syphilis. An electroencephalogram, radioactive brain scan and spinal fluid examination may aid in early identification of mass lesions. Consultation with an oral surgeon, otologist, neurologist or neurosurgeon may be necessary. Repeated nasopharyngeal biopsy, diagnostic nerve blocks, cerebral angiography and pneumoencephalography may be necessary. When a careful search has failed to disclose a cause for face pain or if specific indications are readily apparent, psychiatric consultation should be sought.

SUMMARY

Face pain is a commonly encountered disorder. Neuralgia, atypical facial neuralgia, secondary or symptomatic neuralgia attributable to a structural lesion about the head or neck, to local end organ disease or to systemic disease, and psychogenic face pain are defined as useful diagnostic categories. Successful therapy depends upon precise diagnosis. A clinical approach to the patient with face pain is offered.

ACKNOWLEDGEMENT

The author gratefully acknowledges the counsel and encouragement of M. W. Van Allen, M.D., professor of neurology at The University of Iowa College of Medicine.

REFERENCES

The references noted in this article are available on request from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

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Prenatal Mortality in Iowa, 1963

MURIEL MACKEPRANG, M.A.,
SYLVIA HAY, B.A., and CAROL BENDER, B.A.
San Francisco, California

Prenatal mortality in large populations has not been well described. The major problem of such a descriptive epidemiologic study is finding an adequate source of information about intrauterine deaths occurring from conception to completion of gestation. Under the assumption that medical records are the best single source of such information, the present study was based on all cases of spontaneous abortion and fetal death recorded during 1963 in 144 hospitals in Iowa.

The Iowa State Department of Health, the Iowa Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons and the Iowa Hospital Association endorsed and assisted us in an earlier study of the completeness and accuracy of reporting congenital malformations on birth certificates.[1, 2] That investigation was subsequently enlarged to include fetal deaths and abortions occurring in the same hospitals in order to better estimate the actual incidence of congenital malformations,[3] to measure the underregistration of fetal deaths and to describe prenatal mortality in a large population.

METHODOLOGY

The field operations were carried out under contract by the Statistical Laboratory of Iowa State University under contract number PH 108-65-137. Records of all admissions to the participating hospitals for obstetric reasons were reviewed. After eliminating diagnoses not involving pregnancies and deliveries resulting in live births, all records were abstracted with as much detail as could be found in each patient's file. Further careful editing of the cases excluded hospitalizations for threatened abortion and other non-applicable diagnoses.

Each case was classified according to recorded evidence of pregnancy termination. In the absence of a fetus or embryo distinctions were made according to the reported presence of trophoblastic cells, chorionic villi, decidua, placental tissue, intact vesicle, hydatidiform mole or ectopic implantation. A number of cases that were clearly diagnosed as interrupted pregnancies without further clarifying detail were simply classified as "clinical diagnoses."

Cases were also classified according to length of gestation attained before death, using a priority system in which size of the fetus was considered the most reliable index of gestational age. Fetal measurements in terms of crown-rump or crown-heel length were converted to gestational age by interpolating from Streeter[4] or Scammon and Calkins.[5] In the absence of fetal measurements the gestational age was calculated from the mother's expected date of confinement or from her last menstrual period. In the event that no other data were available, the period of gestation was taken to be the number of weeks reported by the physician. Allocation by reported weeks of gestation has been criticized on the basis of large numbers of cases grouped at four-week intervals; hence, this category was accorded the lowest priority.

RESULTS AND DISCUSSION

Studies of the frequency of prenatal loss based on hospital data suggest that about 10% of known pregnancies fail to terminate in live births. The proportion of such occurrences in hospitals in the present study was 8.1%, a finding close to Schlesinger's 8.9%,[6] and somewhat smaller than the 11.8% found by Stevenson *et al*,[7] or the 12.2% of pregnancies terminating at the Chicago Lying-In Hospital as reported by Sentrakul and Potter.[8] Since many women abort unknowingly or without entering a hospital, actual reproductive loss could be as

The authors are associated with the Division of Dental Health, National Institutes of Health, Public Health Service, Department of Health, Education and Welfare.

TABLE I

PREGNANCY TERMINATIONS UNDER 20 WEEKS GESTATION IN IOWA HOSPITALS 1963, AND IN CHICAGO LYING-IN HOSPITAL, 1951-1965

Type of Termination	Iowa Hospitals Number	Iowa Hospitals Percent	Chicago Lying-In Hosp. Number	Chicago Lying-In Hosp. Percent
Intrauterine pregnancies:				
Fetus absent	2,801	66.9	1,696	63.3
Decidua or trophoblasts	666		509	
Chorionic or placental tissue	1,809		1,109	
Intact vesicle	9		78	
Clinical diagnosis	317		—	
Fetus present	1,267	30.2	825	30.8
Without malformation	1,242		802	
With malformation	25		23	
Other pregnancies:				
Ectopic	102	2.4	145	5.4
Fetus present	11		49	
Fetus absent	91		96	
Hydatidiform mole	19	0.5	15	0.5
Total	4,189	100.0	2,681	100.0

high as the 24% estimated by French and Bierman,[9] the 35% proposed by Tietze,[10] or the 42% estimated by Hertig *et al.*[11, 12]

One of the few comprehensive analyses of the products of pregnancies that terminated early was reported by Sentrakul and Potter.[8] Although their study was based on careful examination of specimens by pathologists, and the present study describes an unsystematic collection of information, Table I shows an impressive similarity in types of loss recorded for gestations of under 20 weeks. In Iowa we found that early losses far exceeded those occurring in the second half of pregnancy. In fact, as shown in Table II, more than half of the cases occurred between the eighth and fifteenth weeks of gestation. We would expect few women who aborted before the eighth week to be hospitalized, another indication that actual prenatal loss is undoubtedly much higher than a hospital census of such spontaneous losses.

Potter,[13] Rogers,[14] Stevenson *et al*[7] mention anencephaly, spina bifida, hydrocephalus and omphalocele as the malformations most often seen in spontaneously aborted fetuses. In the present study these four malformations, as well as almost all others, showed higher rates of occurrence in fetal deaths than in live births. A comparison of rates for selected malformations in live births and fetal deaths found in hospital records in Iowa in 1963 is presented in Table III. The two malformations most frequent in fetal deaths showed pronounced sex differences, with female predominance in anencephaly, and male predominance in hydrocephalus.

Careful studies by Hertig and Rock,[11] Carr,[15, 16] Nishimura[17] and others have revealed that malformations are much more frequent among deaths occurring early in gestation than among prenatal deaths of intermediate

TABLE II

PRENATAL MORTALITY IN IOWA, 1963, BY LENGTH OF GESTATION

Weeks of Gestation	Number & Percent	
Early	4,189	(82.3)
0-7 weeks	443	
8-11	1,706	
12-15	1,110	
16-19	404	
Undetermined*	526	
Intermediate	201	(3.9)
20-23 weeks	126	
24-27	75	
Late	563	(11.1)
28-31 weeks	98	
32-35	115	
36-39	154	
40 or more	196	
Unknown**	140	(2.7)
Total	5,093	(100.0)

* These cases were known to be under 20 weeks by diagnostic definition, although no specific gestational age could be assigned.

** Includes 36 cases known to be over 20 weeks, although no specific gestational age could be assigned.

TABLE III

SELECTED MALFORMATIONS IN LIVE BIRTHS AND PRENATAL DEATHS FOUND IN HOSPITAL RECORDS IN IOWA, 1963

Malformation	Number		Rate per 1000	
	Live Births	Recovered Fetuses	Live Births	Recovered Fetuses
Anencephaly	8	25	.14	12.24
Spina bifida	34	7	.59	3.43
Hydrocephalus	19	15	.33	7.35
Encephalocele	6	2	.10	.98
Cranial or occipital meningocele	5	2	.09	.98
Cleft lip or palate	121	5	2.09	2.45
Esophageal defects	12	1	.21	.49
Omphalocele	14	9	.24	4.41
Imperforate anus or rectal atresia	22	3	.38	1.47
TEV* or clubfoot unspecified	95	12	1.64	5.88
Polydactyly	95	3	1.64	1.47
Reduction deformities	58	5	1.00	2.45
Mongolism	66	3	1.14	1.47
Total records reviewed	57,909	2,042		

* TEV—talipes equinovarus

and late gestation. In fact, lethal malformations are probably a major cause of spontaneous early abortion. In the present study, however, malformations were recorded among only 25 of the 1,267 recovered fetuses under 20 weeks of gestation (2%) in contrast to 107 of the 775 fetuses of 20 weeks or more (14%). Thus, malformations were recorded nearly seven times as frequently for older fetuses than for those whose development ceased before the 20th week. These rates do not necessarily contradict the findings previously cited. Unlike studies designed specifically to examine the aborted embryos, the present study utilized hospital records that by their nature were oriented to maternal conditions. Without special diagnostic aids, and the motivation to use them, it is unlikely that little more than cursory attention would be given to the embryos.

TABLE IV

PRENATAL DEATH RATES BY MATERNAL AGE IN IOWA, 1963 AND ONANDAGA COUNTY, NEW YORK, 1951-1952

Maternal Age	Rates per 1000 Live Births and Fetal Deaths	
	Iowa	Onandaga County
Under 20	61.7	55.4
20-24	65.9	67.0
25-29	72.6	69.8
30-34	92.3	90.7
35-39	126.9	130.7
40 and over	223.8	184.8

Similar methodologies were employed in Schlesinger's investigation of prenatal mortality in Onandaga County[6] and in the present study. Table IV shows a comparison of the maternal age distribution in the two studies. Large increments in the rates of loss that began at the thirtieth year demonstrates the association of increased prenatal mortality with advanced maternal age. In a study confined to early spontaneous abortions occurring at the Boston Lying-In Hospital, MacMahon, Hertig, and Ingalls[18] concluded that the effect of maternal age was so marked that the alternative influence of birth order would require an association of unlikely magnitude. The data in the present study are insufficient to test the strength of parity in relation to that of maternal age.

SUMMARY

All records of spontaneous abortions and fetal deaths occurring in 144 hospitals in Iowa in 1963 were reviewed. These prenatal losses represented 8.1% of known pregnancies in Iowa during the year. More than 80% of the prenatal deaths occurred prior to the twentieth week of gestation. Malformation rates among prenatal deaths exceeded those among live births. Prenatal loss was associated with advancing maternal age.

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The references noted in this article are available from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

RESOLUTIONS FOR THE NEW YEAR

A number of changes have been made in your JOURNAL during the past year. Many of our readers have commented to me about various aspects of the content as well as the format of various issues. Our thanks go to those who have shown an interest. We are attempting to make the JOURNAL serve you, by making each issue less cumbersome, with shorter articles, new concise discussions, broader interests covered, and so on.

Authors of scientific articles are encouraged to get to their thesis without a lot of irrelevant material that attests to the efficiency of a secretary in a medical library. The message to be presented through the authors' work and thinking is much more valuable. Certainly we do not wish our JOURNAL to be a series of abstracts; we want it to be representative of good medical reporting based on sound medical knowledge and experience.

The New Year brings new hopes and desires. We desire to represent you and hope that you approve of our efforts. The editorial staff of your JOURNAL stands ready to assist you in your scientific articles, solicits your continued good submission of manuscripts and will do all in our power to produce a medical journal of worth. Happy New Year to All of You!—M.E.A.

SPEAK OUT!

Do you review the remittance invoice attached to the checks received in payment of Title XIX Medicaid claims? If you do not it would pay you to do so, doctor. At least have your bookkeeper keep you informed and question all payments which seem unreasonable or out of line with your billings.

The understanding of all the regulations, the changes of policies and the decisions regarding the payment of claims often times require the special knowledge of a lawyer. The discussions necessary to alter the decisions may require the persuasiveness of a politician, and the patience of Job is required in the preparation and revision of the necessary forms.

Compare the actual costs of injectable drugs with the allowances given. In one instance in my office last month the allowance was 65 cents less per injection than the actual cost. That may seem a small amount but when multiplied can mount to a fair sum. In another instance, a payment was made of 70 cents per day for hospital visits to a patient seen in consultation. That's right—70 cents per day. The explanation . . . computer error. Discussion settled the matter. The computer will be reprimanded and proper payment will be made. However, it would not have been without the protest.

Do not be backward about seeking to correct apparent errors. You can be sure that if you make an error in a report to the Internal Revenue Service an explanation will be demanded along with payment plus interest. Know the facts, present them in a precise manner, speak to the right people and receive what you rightfully have coming to you.—M.E.A.

ALL PHYSICIANS SHOULD SHARE

The actions of the Iowa Medical Society have a direct bearing on the socio-economic well-being of all physicians. Similarly, these activities and decisions have a direct effect on the quality of medicine we provide, and this of course may be correlated with the welfare of our patients.

The officers of the Society and those who serve actively on committees are deeply aware of the consequences of their actions. They also are aware that some of the criticisms of their actions are sincere in their motivation. These honest criticisms are helpful.

However, it is discouraging to have a few members of the profession resign or become inactive simply because they do not accept some actions approved by the majority.

There are inequities in representation and there is need for change in this and in other areas. But the changes should be made thoughtfully and deliberately. We need the help and cooperation of all physicians. It is important that all "belong" and be active.

Plenty of unfounded adverse comment is aimed at us through the media and other sources. During the next few years our numbers will be increased. It is hoped we may be united during this period and not splintered into separate organizations with limited effectiveness.—RALPH L. WICKS, M.D., *Boone, Chairman, IMS Board of Trustees*

ON MUSCULOSKELETAL TUMORS

The most recent statistics on cancer deaths in the United States indicate 1,600 people will die of bone sarcomas, 1,400 of soft tissue sarcomas, 3,900 of multiple myeloma, 520 of reticulum cell sarcoma (lymphoma starting in bone), for a total of 7,400 individuals. This represents less than one-half of one percent of the 315,000 deaths from cancer of all types. If one excludes the myelomas and reticulum cell sarcomas, one-third of the bone and soft tissue sarcomas occur in children under 15 years of age. Seven percent of all tumors in children are musculoskeletal, third most common after leukemia (many with bone involvement) and brain and CNS tumors.

When one considers that approximately 1: 100,000 population die of musculoskeletal sarcoma (approximately 27 for Iowa), no one institution or individual would have a very large sample for analysis and study. It is estimated for every cancer death, an additional two patients are alive and under treatment. This results in a rather small sample of approximately 9,000 patients under care in the entire country. Herein lies the major problem for the management of musculoskeletal tumors—lack of concentration of patients in centers where more concentrated and intensive study of the patient sample for clinical research or basic research on the problem could be done. Equally important at such centers, better utilization of current knowledge in diagnosis and treatment would be possible. It would be preferable for general practitioners, surgeons, and orthopaedic surgeons who see an occasional primary musculoskeletal neoplasm to refer the patients immediately to a center where a team of orthopaedic surgeons, radiologists, pathologists, radiation therapists, nuclear medical specialists, medical oncologists and immunologists could concentrate their efforts. This could prevent (1) disfigurement and disability in those instances of benign skeletal lesions mistaken for malignant tumors and over-treated, or (2) delay in treatment of malignant tumors while multiple consultations are sought by mail, whenever local interpretation of the lesion is in dispute. Combined treatment modes could improve survival 20 to 25 percent overall.

Primary tumor of bone in children is one of the most distressing problems an orthopaedic surgeon must face. In addition to great discomfort and disfigurement imposed upon the child by his disease, and its treatment by amputation or irradiation or both, this has a great impact on the parents. Disability cannot be measured in terms of adult standards, but it is there nonetheless in loss of time in school and probable requirement of a prosthesis for loss of a limb. During the past 10 to 15 years there has been improvement in childhood amputee management. There is little doubt the best course of action is to fit the child with a prosthesis in spite of a poor prognosis for many of the primary sarcomas of bone or soft tissue. The adverse psychological effect on the child and family is greatly diminished by this approach.*
—MICHAEL BONFIGLIO, M.D., *Iowa City*

* Supported in part by Public Health Service Clinical Cancer Training Grant T12 CA 08084.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

THE VANISHING JOURNAL?

Several months ago I voiced some thoughts on Toffler's *Future Shock*. That book triggered some musings about the impact of future shock on academic medicine—musings by Eugene Braunwald, new head of internal medicine at Harvard (N. Eng. J. Med. 286:1031, 1972). You may not feel close to academic medicine, yet the functions which comprise academic medicine will, in my opinion, have much impact on all of medicine, your practice included (unless you're close to retirement).

Dr. Braunwald contends ". . . academic medicine will never again be able to return to its previous state of semi-isolation and will not be protected from the hurricanes of change." The word "hurricane" was carefully chosen and serves not merely to avoid the cliché of "winds of change." You may not feel it as fully where *you* stand, but those winds are brisk and stinging in the academic community.

Dr. Braunwald's predictions are worth your consideration. One hit me with special force. He forsees the declining importance and influence of that major source of medical continuing education, the monthly journal. Such journals take much pains, through their process of critical review, to insure accuracy and quality. But the time delay in accomplishing such review will prove lethal, in Dr. Braunwald's opinion. He sees audio and videotape journals and tabloid-type medical newspapers as the answer to currency. Consistent with the general thesis of *Future Shock*, the necessary compression of our time scale and the rapidity of new discovery will oblige us to forego the luxury of careful (slow) review designed to uphold "publication standards." Such change would force us all to an exceeding hypertrophy of our powers of critical assessment, lest in our state of judgmental weakness

(Please turn to page 27)

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

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Journal Book Shelf

BOOK REVIEWS

CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT, Second Edition, ed. by *C. Henry Kempe,* M.D., *Henry K. Silver,* M.D., and *Donough O'Brien,* M.D. Los Altos, Calif., Lange Medical Publications, 1972, $12.00.

The senior authors and 48 associates at the University of Colorado combine their efforts to give us a second edition of a concise, though 982 pages, discussion of pediatric diagnosis and treatment. The soft-bound book is well-organized, the figures and tables are appropriate to the text, and the references pertinent to the subject under consideration. Though numerous authors are involved, the main subjects are written along a basic outline to provide a continuity of organized presentation. For example, each major disease is introduced by a brief list of "essentials of diagnosis" leading the reader to general considerations of the subject, clinical findings, differential diagnosis, treatment and prognosis.

I am impressed by the wide coverage of the vast subject of pediatrics in this presentation. The book is recommended to pediatricians and generalists alike. For $12 there are very few similar bargains. *M. E. Alberts,* M.D.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, Fifth Edition, by *George A. Ulett,* M.D., Ph.D., St. Louis, C. V. Mosby Company, 1972, $10.90.

The difficulty in writing a synopsis for an entire medical specialty derives not merely from the need for brevity, but for specificity and high reliability of the statements made. In a discipline with a high order of objectivity, this is not so hazardous, but in one such as psychiatry, the task is almost impossible. In this tautly written, compact volume, the material dealing with organic phenomena, with tests and with psychotropic medications and "physical" therapies, is well presented and easily accessible. In those sections dealing with phenomenological data, psychological theories and psychological therapies, the text suffers from a common ailment, namely, imprecision of language and meaning. This in turn derives from the fact the descriptive vocabulary of psychiatry has even today not achieved any universal agreement as to definition and usage.

Despite this limitation, this synopsis has definite practical value for students and for physicians interested in having a handy, concise psychiatric reference book. *Sidney L. Sands,* M.D.

BONE TUMORS, Fourth Edition, by *Louis Lichtenstein,* M.D., St. Louis, C. V. Mosby Company, 1972, $24.50.

This book is considered a classic by most orthopaedic surgeons, radiologists and pathologists. Much of it is original work done by Dr. Lichtenstein. He has played a large role in sorting and classifying bone tumors in a manner acceptable to most pathologists. This effort has helped orthopaedic surgeons to plan and evaluate treatment of these difficult lesions. In addition to this, I am sure radiologists have benefited by Dr. Lichtenstein's work.

The fourth edition has a brief new chapter on certain rare primary tumors in bones, i.e., leiomyosarcoma and malignant mesenchynoma. The author advises abandoning the term "adamantinoma" and substituting "dermal inclusion tumors of bone."

The book is written in a clear, concise style. *John H. Kelley,* M.D.

A DECADE OF PROGRESS—THE UNITED STATES ARMY MEDICAL DEPARTMENT 1959-1969, by *Lt. Gen. Hal B. Jennings, Jr.,* Washington, D. C., Superintendent of Documents, U. S. Government Printing Office, $2.25.

This is really a story of the leadership of General Leonard D. Heaton. Innovations made in the 10-year period are carefully covered—the inauguration of open heart surgery, treatment of drug abuse, improvements in radiology, chest surgery, vascular surgery, etc.

All new hospitals are described as are the renovations and additions to fixed hospitals. Covered are the actual operations of units in the field in Vietnam, Lebanon, the Cuban and Dominican crises, earthquakes and floods in Chile, Yugoslavia and Alaska. *C. Harlan Johnston,* M.D.

THE CARE OF MINOR HAND INJURIES, Second Edition, ed. by *Adrian E. Flatt,* M.D., St. Louis, C. V. Mosby Company, 1972, $21.50.

The first and second editions of this book (1959 & 1963) have been well received. The third edition was published in April 1972. It contains many new illustrations, but the general format remains the same.

The first section concerns general principles. Dr. Flatt gives valuable information on anatomy, the mechanics of the hand and the testing of function, both motor and sensory. In the second section specific treatment of the lesions of skin, bone, joint, tendon and nerve are discussed. The author's extensive experience and mature judgment are manifested.

The surgeon who treats hand injuries should have this volume on his desk. The author's style makes the text eminently readable. *Julian M. Bruner,* M.D.

REVIEW OF MEDICAL PHARMACOLOGY, Third Edition, ed. by *Frederick H. Meyers*, M.D., *Ernest Jawetz*, Ph.D., M.D., and *Alan Goldfien*, M.D., Los Altos, Calif., Lange Medical Publications, 1972, $8.50.

The modern physician is confronted daily with a plethora of new and often, very potent medications whose utility is touted by their developers and whose actions are often as unclear as they are complex. The situation is complicated further by the fact that the conscientious physician must understand not only the pharmacologic properties of individual products, but the interactions of such with each other within the patient. Few practitioners can be thoroughly informed regarding all drugs their patients may be taking, but the individual doctor can have available a few ready sources of information.

It is not often we think of keeping a "pharmacology" text among our accessible books. In the present instance, we have one to be recommended for the purposes mentioned. It is "medically" oriented and so organized as to provide easy access to classes of drugs according to their principal sites of action and clinical uses. The table of contents and index are well designed and the text material is sufficiently outlined to permit rapid finding of specific data. An appendix details the effects of commonly used drugs on routine laboratory tests—a matter not always considered in the course of patient study. All in all, this is a very desirable reference work for the practicing physician. *Sidney L. Sands*, M.D.

CALL THE DOCTOR, by *Robert F. Polley*, M.D., Seattle, Washington, Parents Handbooks, 1971, $3.00.

Some subjects in this small book are controversial, yet Dr. Polley takes them in stride and demonstrates a knack for dealing with common problems of parents. The informative book for parents answers a wide range of questions in language which can be understood. Some advice is a bit strong but still has definite merit. For example, in the discussion of behavior problems, Dr. Polley suggests rather strong approaches to the "class clown," even to the point of making the little con-artist cry.

I recommend this book not only to parents, but to physicians who care for children. *M. E. Alberts*, M.D.

CIVILIZATION AND SCIENCE—IN CONFLICT OR COLLABORATION? Ciba Foundation Symposium. New York, Associated Scientific Publishers, 1972.

This report is of a symposium in London (June 28-30, 1971) and would be of interest mainly to pure scientists and economists. There is some discussion of importance to practicing physicians. The point is made that funds for military research exceed by far expenditures for medical research. The papers evaluate the relationship of science to our social state as well as civilization itself. *M. E. Alberts*, M.D.

CONFESSIONS OF A GYNECOLOGIST, by *Anonymous*, M.D., Garden City, New York, Doubleday & Company, Inc., 1972, $7.95.

Provocative chapter headings—"What I Don't Tell My Friends," and "Please, Remove Your Clothes, Madam"—make this a "fun" book. Yet, there are also some revelations on the practice of gynecology that demonstrate the joys as well as the occasional pathos of pregnancy and childbirth. The author reveals his feeling quite pointedly at times. He leaves no doubt about his opposition to fathers in the delivery room. These men are pictured as a bit peculiar—either demonstrating sheer curiosity, deriving thrills from visual sex, or psychotically jealous. If you want a composite exposé of a gynecologist's views on his daily experiences, this book will be enjoyable. *M. E. Alberts*, M.D.

BOOKS RECEIVED

OBSERVATIONS IN MIDWIFERY by *Percivall Willoughby*, M.D. Yorkshire, England, S. R. Publishers, Ltd., 1972, $3.50.

CALL THE DOCTOR by *Robert F. Polley*, M.D. Seattle, Washington, Parents Handbooks, 1971, $3.00.

COMPREHENSIVE REVIEW FOR MEDICAL ASSISTANT by *M. Murray Lawton*, M.D., and *Donald F. Foy*, B.S., M.S., M.P.H. St. Louis, C. V. Mosby Company, 1972, $5.50.

REVIEW OF MEDICAL PHARMACOLOGY, Third Edition, ed. by *Frederick H. Meyers*, M.D., *Ernest Jawetz*, Ph.D., M.D., and *Alan Goldfien*, M.D. Los Altos, California, Lange Medical Publications, 1972, $8.50.

A CIVILIAN DOCTOR IN VIET NAM by *Fred Gloeckner*, M.D. Philadelphia, The Winchell Company, 1972, $5.00.

CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT, Second Edition, by *C. Henry Kempe*, M.D., *Henry K. Silver*, M.D., and *Donough O'Brien*, M.D., F.R.C.P. Los Altos, California, Lange Medical Publications, 1972, $12.00.

MALNUTRITION, Volumes I and II, by *John R. K. Robson*. New York, Gordon and Breach, 1972.

EATER'S DIGEST by *Michael F. Jacobson*. Garden City, New York, Doubleday & Company, Inc., 1972, $5.95.

CONFESSIONS OF A GYNECOLOGIST by *Anonymous*, M.D. Garden City, New York, Doubleday & Company, Inc., 1972, $7.95.

LIPIDS, MALNUTRITION AND THE DEVELOPING BRAIN, Ciba Foundation Symposium, ed. by *Katherine Elliott*. Amsterdam, Associated Scientific Publishers, 1972.

PEPTIDE TRANSPORT IN BACTERIA AND MAMMALIAN GUT, Ciba Foundation Symposium, ed. by *Katherine Elliott* and *Maeve O'Connor*. Amsterdam, Associated Scientific Publishers, 1972.

CARBON-FLUORINE COMPOUNDS, Ciba Foundation Symposium, ed. by *Katherine Elliott* and *Joan Birch*. Amsterdam, Associated Scientific Publishers, 1972.

PRACTICE OF SURGERY, Volume I, by *Walter F. Ballinger*, M.D., and *Theodore Drapanas*, M.D. St. Louis, C. V. Mosby Company, 1972, $23.50.

URINARY TRACT INFECTION AND ITS MANAGEMENT, ed. by *Donald Kaye*, M.D. St. Louis, C. V. Mosby Company, 1972, $22.50.

SYNOPSIS OF SURGERY, 3rd Edition, by *Richard Liechty*, M.D., and *Robert T. Soper*, M.D. St. Louis, C. V. Mosby Company, 1972, $15.50.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, Fifth Edition, by *George A. Ulett*, M.S., M.D., Ph.D. St. Louis, C. V. Mosby Company, 1972, $10.90.

SURGICAL DISORDERS OF THE PERIPHERAL NERVES by by *Sir Herbert Seddon*, C.M.G. Baltimore, Williams & Wilkins Company, 1972, $32.25.

MEDICINE IN A CHANGING SOCIETY by *Lawrence Corey, et al.* St. Louis, C. V. Mosby Company, 1972, $6.50.

THE PARENTS' GUIDE TO DRUGS by *Matthew Andrews*. New York, Doubleday & Company, 1972, $2.50.

PRACTICAL AUTOMATION FOR THE CLINICAL LABORATORY, Second Edition, ed. by Wilma L. White, B.A., F.A.I.C., Marilyn M. Erickson, B.S., and Sue C. Stevens, B.A., M.A., Ph.D., F.A.I.C. St. Louis, C. V. Mosby Company, 1972, $22.50.

PEDIATRICS, Fifteenth Edition, ed. by *Henry L. Barnett*, M.D., and *Arnold H. Einhorn*, M.D. New York, Appleton-Century-Crofts, 1972, $26.50.

LABORATORY MEDICINE, HEMATOLOGY, Fourth Edition, ed. by *John B. Miale*, M.D. St. Louis, C. V. Mosby Company, 1972, $27.50.

HANDBOOK OF MEDICAL TREATMENT, Thirteenth Edition, ed. by *Milton J. Chatton*, M.D. Los Altos, California, Lange Medical Publications, 1972, $6.50.

Doctor's Business

by LARRY E. LEAVERTON

TOO MUCH BUSINESS MINDEDNESS?

Happenings in medical practice in 1972 and in recent years have been complex from a business standpoint. Many doctors, accustomed to a somewhat simple style of practice, are now involved in (1) group practice, (2) professional corporations, (3) increasingly in third party payments with the resulting controls and regulations, and (4) with a wage-price freeze which has its complex interpretations and ramifications. Many other problems face the physician in addition to the daily array of patient problems.

Most of us do not like to classify medical practice as a business. Yet, conditions make it imperative for today's physician to be aware of the business side of his practice.

For example, our income tax regulations make complete and accurate records mandatory. These records offer the side benefit of providing information helpful in the administration of a practice. The current price freeze regulations, which include the health industry even more than other businesses and professions, is another example of the need for physician awareness. Provisions for maintaining for public inspection a schedule of base fees are still in force. Also still in effect is the limitation of a 2½% increase of aggregate fees. This increase is subject to the requirement of staying within the base period profit margin—two of the last three years prior to August 1971. In our experience, while this is restrictive, the majority of physicians have weathered the price freeze fairly well. It has made them more aware of their costs and productivity.

Physicians who have incorporated their practices are now corporation executives and administrators. They must hold board meetings, keep minutes, make decisions on salary administration, forecast, budget and invest funds in profit sharing and pension funds, and wrestle with restrictive regulations. The corporate way is more formal, complicated and time consuming. In many cases, particularly in group practice, this can result in better administration, as good business practice is a requirement. In terms of management and leadership, a corporation has the advantage of operating under statutes which require a formal organization with clearly defined control, authority and responsibility. This has the effect, particularly in the larger groups, of creating a central management where the policy and decision making process may be more effective than in partnerships or associations where authority is often divided or spread too broadly. It can also force budgeting of personal living expenses due to the reduction in spendable income. Some doctors previously unable to save have accumulated investments through a professional corporation plan because of the fixed salary, the monthly withholding of income taxes, and the before tax investment. If a doctor is not willing or able to reduce his spendable income he should not incorporate.

One advantage to a soundly administered medical practice is that through it more doctors may look forward to some financial security at

(Please turn to page 28)

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

IMS JOURNAL—A CHRONICLE FOR 7 DECADES

THE JOURNAL OF THE IOWA MEDICAL SOCIETY is the official chronicle of the state's medical profession. We call attention to this fact this month as the JOURNAL changes its volume number from 62 to 63. By doing so the JOURNAL moves further into its seventh decade of publication.

Several forerunners to the present JOURNAL existed under different names: *Western Medico-Chirurgical Journal, The Iowa Medical Journal, Iowa Catlin, Iowa State Medical Reporter, The Vis Medicatrix* and *The Tri-State Medical Journal.* These early efforts had relatively brief life spans.

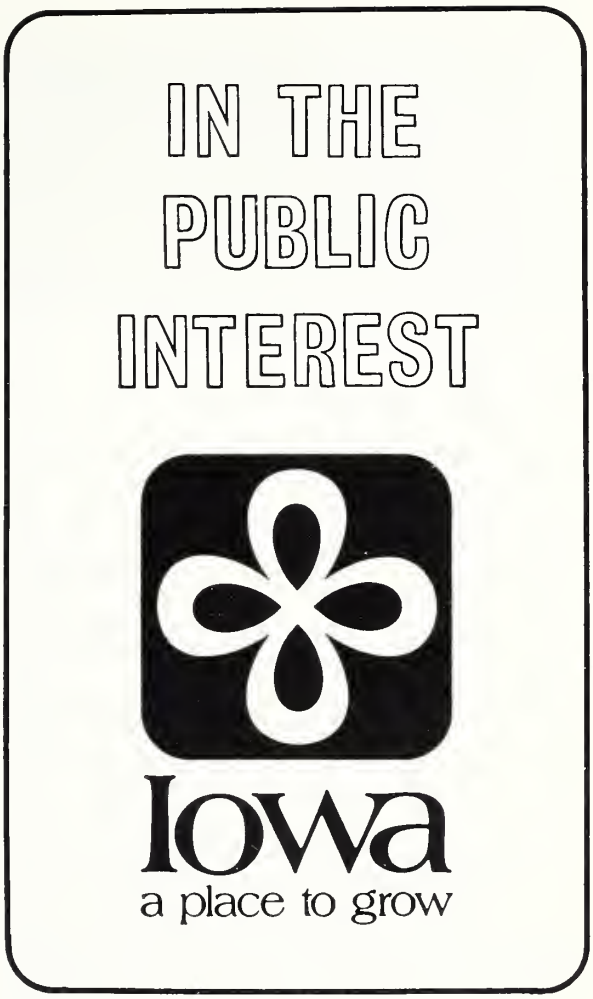
The JOURNAL OF THE IOWA MEDICAL SOCIETY came into being in 1911 with approval of this resolution by the policy-making House of Delegates: *"That the House of Delegates establish an official* JOURNAL OF THE IOWA STATE MEDICAL SOCIETY *and that the same be called the* JOURNAL OF THE IOWA MEDICAL SOCIETY."

The plethora of scientific writing which has filled the JOURNAL OF THE IOWA MEDICAL SOCIETY, and its predecessor publications, constitutes a fascinating panorama of medical progress. From the first article which appeared in 1850 in the first issue of *Western Medico-Chirurgical Journal* under the title, "Rheumatic Carditis—Autopsical Examination," to the January 1973 article entitled, "Discoid Menisci," the scholarly writing of Iowa physicians has added much to the total book of medical knowledge.

The JOURNAL OF THE IOWA MEDICAL SOCIETY (circa 1973) is published monthly in a quantity of 3,000. It is distributed to the physician members of the Society and to others whose interest is sufficient to pay the $5 annual subscription. In addition to publishing submitted and selected scientific articles, prepared primarily by and for Iowa physicians, the JOURNAL offers its readers additional information and news highlights in the interest of keeping them aware of what's happening in the field of health care delivery, particularly in Iowa.

Through the years editors of the JOURNAL have endeavored to provide their physician readers diversified, topical and provocative information. The JOURNAL'S editorial philosophy today seeks to reflect the busy lifestyle of the Iowa physician who has an abundance of published material from which to pick and choose and precious little time for any of it. The JOURNAL strategy is to provide short, concise material, scientific and otherwise, which can be scanned quickly and still provide input worthy of the time investment.

That the IMS JOURNAL constitutes a diary for the medical profession might best be illustrated here by selecting brief and random pas-



sages from issues separated by 10-year intervals. Here are quick excerpts back to 1913:

JANUARY 1963—"The Sabin oral polio vaccine got its first widescale use, and by year's end had created somewhat of a storm. There were reports of a few cases of Type III polio (nationally) following inoculation with the Sabin Type III vaccine. However, Dr. Albert Sabin said his studies showed no evidence that the cases were linked with his vaccine. At any rate, the incidence of polio appeared headed for an all-time low."

JANUARY 1953—". . . we were receptive to Dr. Read's book, 'Childbirth Without Fear,' when it began to receive publicity from the lay press in 1947. Soon after that, a few patients began asking for a chance to try the method. The results were amazing, but we felt the patients really needed class work, practice, more expert guidance and support during labor. . . . The 669 cases we are reporting are consecutive deliveries from January 1, 1951, to April 1, 1952, except those of less than 28 weeks gestation." *From an article by H. L. Miller, M.D., and F. E. Flannery, M.D., Cedar Rapids.*

JANUARY 1943—"Scurvy has been a medical curiosity for the past two decades. The author saw but one instance of this disease between 1927 and 1941. At this time it seemed suddenly to reappear, and in 12 months' time there occurred six established or presumptive cases of scurvy in his practice. . . . There appears to be a general recurrence of interest in this condition, literature on the subject has increased considerably. . . . Since we are at war, a reference to scurvy as a military hazard is also of interest." *From an article by R. H. McBride, M.D., Sioux City.*

JANUARY 1933—"Think what insulin means to the diabetic patient; liver extract to the perniciously anemic. Would anyone, no matter what the cost, go back to the days of cholera and yellow fever? Would anyone wish to discard antitoxin and the x-ray? Preventive medicine and scientific diagnosis are largely responsible for our decreased mortality." *From an article by G. F. Harkness, M.D., Davenport.*

JANUARY 1923—"Having reached the present high state of efficiency it remains for the Council on Medical Education (of the AMA) to work out and adjust some of the defects which will bring medical education into accord with the changing conditions of medical practice both as to the needs of the public and the profession itself." *From an editorial by D. S. Fairchild, M.D., Clinton.*

JULY 1913 (This was the first issue of the year)—"How far Socialism will enter into the practice of medicine cannot be determined, although it has become an established fact in England and Germany. The difference in governmental ideas in America as compared with those of many European countries, may postpone serious governmental interference for many years, but we are changing so rapidly in our notions of the functions of the government of states and of the nation, that we cannot be sure of what is in store for us. In England the opposition of the profession for some time bid fair to prevent the Government medical benefit being put into force, but it so happened in certain areas for one reason or another that the profession gave in and accepted the Government proposition with some modifications." *From an editorial by D. S. Fairchild, M.D., Clinton.*

The important elements of change, progress, concerned interest, etc., are apparent even in these vignettes of the past. The days ahead will involve new personalities, but they too will have their satisfactions, breakthroughs, frustrations, etc. *Welcome 1973!*

Radiology Window

by DONALD C. YOUNG, M.D.

CASE NO. 9

This abdominal aortogram was performed on a 48 year old woman who was normotensive until three years ago when mild arterial hypertension was discovered on routine physical examination. The response to medical management was satisfactory until approximately six months ago when a persistent systemic arterial hypertension developed which at times ranged as high as 300/160 mm of HG. The aortogram shown here was performed for specific evaluation of the renal arteries and shows one process responsible for renovascular hypertension. Turn to page 28 for an additional X-ray and discussion.

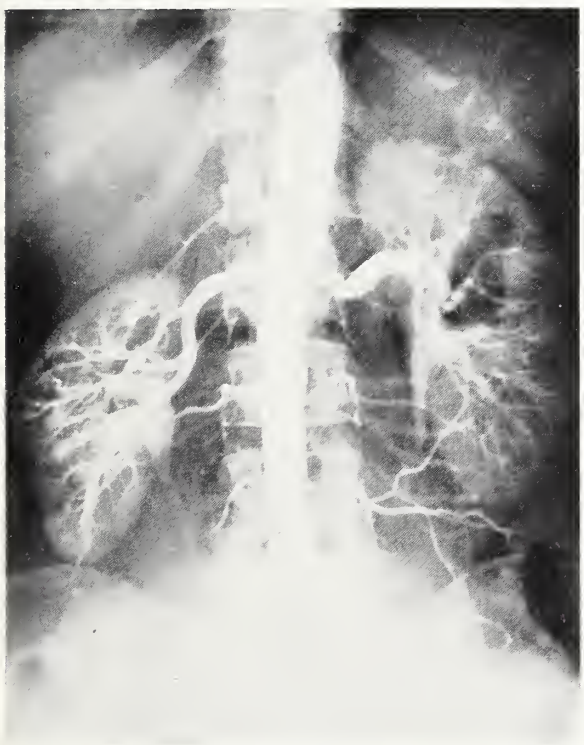


Figure 1

This radiologic feature has been prepared and provided by Donald C. Young, M.D., who is associated with the Department of Radiology at Iowa Lutheran Hospital in Des Moines.

EDUCATIONALLY SPEAKING

(Continued from page 21)

we be buffeted dreadfully by all manner of careless science plus shoddy journalism. Perhaps we should all enroll forthwith in refresher courses in propaganda analysis and scientific method, if the editors we have grown to trust over the years are to be replaced by others concerned with immediacy and newsworthiness rather than scholarly accuracy, balance and objectivity.

But maybe the prediction will fail. For some years, I've heard it predicted the book will soon vanish from our world like the passenger pigeon. Like most such predictions, there is no date attached, and perhaps I'll simply have to wait much longer for its fulfillment. You remember Mark Twain's famed comment, "Rumors of my death have been greatly exaggerated." Yet, those rumors proved eventually true, which even Mr. Twain will no longer deny.

RADIOLOGY WINDOW

CASE NO. 9

The selective left renal arteriogram shown here displays a one centimeter in length stenotic area at the origin of the left renal artery. Some poststenotic dilation of the distal renal artery is also shown.

Recognition of renovascular hypertension has been complicated by a lack of suitable diagnostic procedures as well as by the fact that renovascular disease is relatively common in the normotensive and hypertensive population and co-existence does not absolutely indicate a cause-effect relationship. A few clinical features help distinguish renovascular from essential hypertension. A renovascular basis should be suspected with the sudden onset or increased severity of hypertension or in hypertension developing after acute back pain or trauma or with unexplained hypokalemia. An upper abdominal bruit is audible in approximately 50% of renovascular cases.

The most useful screening procedure is the intravenous pyelogram which reveals the ischemic kidney to have a smaller renal mass with at times delay in appearance and late hyperconcentration of the contrast medium. Renal angiography should be used when further diagnostic workup is indicated either by other abnormal screening tests or the clinical severity of the hypertension. In older individuals, particularly males, arterial stenosis is usually on an atherosclerotic basis and tends to involve the proximal one-third of the renal artery. In younger patients, usually females, an unusual fibrotic process causes the arterial narrowing which may produce intimal or medial fibrosis, elastic tissue degeneration and



Figure 2

aneurysmal dilation. At the time of the angiogram additional investigation can be performed to determine if the stenotic lesion is functionally significant; this might include studies to determine renin or angiotensin activity in the renal venous blood from the involved kidney.

Surgical therapy is usually indicated in younger patients with good renal function and unilateral arterial stenosis. The involved renal artery can usually either be resected or bypassed with a graft. In this group of patients the hypertension will be eliminated or improved in 80 to 90 per cent with a low operative morbidity and mortality.

DOCTOR'S BUSINESS

(Continued from page 24)

retirement. The Self Employed Retirement Plan, professional corporation profit sharing and pension plans, adequate insurance programs and prudent individual investment plans provide this assurance.

Too much business mindedness? Perhaps. But there are by-product advantages to these changes and complexities. Awareness of costs of medical practice, better managed and more efficient practices resulting in benefits to the patients, and better informed doctors are the expected result.

About IOWA Physicians

Dr. Howard G. Beatty, Creston, attended recent course on diagnosis and treatment of cancer at Harvard Medical School of Continuing Education in Boston. . . . **Dr. Walter M. Bloek,** Cedar Rapids, spoke recently to Coe College education students on the "Hyperactive Child." He also presented a paper on "Cerebral Dysfunctions," at November meeting of Pan-American Medical Society in Miami Beach. . . . **Dr. Mark Thoman** has returned to Des Moines from Seattle to join Dr. Ruby Cureg in pediatrics practice. Dr. Cureg assumed Dr. Thoman's Des Moines practice when he left for Seattle. . . . **Dr. H. W. Berthelsen,** Rock Valley, retired from medical practice in November. Dr. Berthelsen moved his practice to Rock Valley in 1966; he was in Hawarden before. He is medical graduate of University of Kansas. . . . **Dr. Basen M. Dajani** has assumed Des Moines medical practice of recently retired **Dr. Louis Noun.** Dr. Dajani is native of Palestine, Jerusalem and studied at American University, Beirut, Lebanon. He's board certified in both allergy and immunology and internal medicine. He served a residency at The U. of I. College of Medicine. . . .

Dr. William O. Griffith, Council Bluffs, received a plaque at Creighton University's Foundation Day recognizing his 25 years of teaching service. . . . **Dr. Richard L. DeGowin,** associate professor of internal medicine and radiation research at The U. of I. College of Medicine, is new president of Midwest Section of the American Federation for Clinical Research. . . . **Dr. and Mrs. Fred Montz,** Lowden, were honored by fellow citizens in November. Open house fete recognized their golden wedding anniversary and Dr. Montz' 50 years of practice. Dr. Montz was graduated from The U. of I. College of Medicine in 1921 and opened his Lowden medical practice in 1922. . . . **Dr. Mary Gannon,** a urologist, is new medical staff member at Spencer Municipal Hospital. She's a 1966 U. of I. College of Medicine graduate, served an internship in Worcester, Massachusetts, and a urology residency at the University of Wisconsin. . . .

Dr. Gail M. Proffitt, director, Iowa State University Student Health Service, has received a plaque recognizing her service in student health field. Honor was bestowed by North Central College Health Association at its recent annual meeting in Yankton, South Dakota. . . . New Medical Science Library and Learning Center at Mercy Medical Center in Dubuque memorializes a prominent Dubuque physician, the late **Dr. Anthony C. Pfohl.** The Dr. Anthony C. Pfohl Medical Science Library is for staff and personnel at the three Dubuque hospitals, plus staff of other area health care institutions and those pursuing health careers. . . . **Dr. William B. Bean,** Osler Professor of Medicine at The U. of I., is author of foreword in new book, "Richard Asher Talking Sense," published by Sir Isaac Pitman and Sons, London. Book is to be published in U. S. by University Park Press, Baltimore. It is a collection of clinical essays by the late British physician. "Walter Reed in Florida" was title of a Dr. Bean lecture at November annual meeting of the American Clinical and Climatological Association. . . .

At November meeting of Wright County Medical Society, **Dr. Dorothy Ehmke,** U. of I. associate professor of pediatric cardiology, presented a program on "Cardiac Auscultation." Physicians from three counties adjoining



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Wright attended. . . . **Dr. A. Clark Hyden,** Sioux City, is new Fellow of American College of Chest Physicians. He was inducted at ceremonies during College's recent annual scientific assembly in Denver. . . . **Dr. George L. Baker,** assistant dean, medical student affairs, U. of I. College of Medicine, participated in workshop on "Adapting Teaching—Learning Process in Redefined Goals of Medical Education" at recent 4th World Conference on Medical Education in Denmark. He also presented a paper on "Education of Physicians in a Rural State—Effect on Rural Health Personnel" at International Conference on Education in Health Sciences in The Netherlands. . . . **Dr. Kenneth J. Gee,** Shenandoah, attended a recent three-day postgraduate course at Mayo Graduate School of Medicine in Rochester. . . .

Dr. Gilbert Clark and **Dr. Jean S. LePoidevin** were guest speakers at recent conference of Iowa County Attorneys Association. The Waterloo physicians discussed the "battered child" and problems in handling these cases. . . . **Drs. Maurice Van Allen, William Bell,** and **Richard Finchman,** U. of I medical faculty in Department of Neurology, participated in recent Coralville conference on epilepsy sponsored by The Epilepsy Association of Area X. . . . **Dr. Lawrence DenBesten,** Iowa City, and **Dr. Richard Sedlacek,** Cedar Rapids, participated in recent ostomy patient visitation program in Cedar Rapids. Dr. DenBesten spoke on "Ostomy Surgery: What It Means," and Dr. Sedlacek discussed "The Physician's Role in the Ostomy Visitation Program." . . .

Dr. J. A. Broman, of Maquoketa, was presented the Distinguished Service Award of Luther College at recent homecoming activities. The Distinguished Service Award is given annually to Luther College alumni and friends for contributions to community, church, state and nation. Citation to Dr. Broman read: "As a physician, churchman and civic leader, Dr. John Broman is making an outstanding contribution to society and man's welfare." Dr. Broman is a partner in the Maquoketa Medical Center. He's the county medical examiner and chief surgeon at Jackson County Hospital. He also recently received the Maquoketa Chamber of Commerce Distinguished Service Award. . . .

Dr. Cornelius Maris, of Sanborn, was honored by his community October 23. On "Dr. Maris Day," so designated by the Sanborn mayor, Dr. Maris was recognized for unselfish devotion to his profession and for many years of dedicated service to the community. Dr. Maris received the M.D. degree and completed his internship and residency at The U. of I. College of Medicine. He's practiced medicine in Sanborn since 1929. . . .

Dr. Robert D. Pernet and **Dr. Joseph M. Esposito** have opened a joint practice in building previously occupied by **Dr. Donald W. Hurlbut** in Elkader. Dr. Pernet received the M.D. degree at the University of Wisconsin Medical School and completed his internship at Youngstown, Ohio. Dr. Esposito is a graduate of the College of Osteopathic Medicine and Surgery in Des Moines. He completed his undergraduate work at Mt. St. Mary's College in Emmetsburg, Maryland. Dr. Esposito practiced previously in New Hampton. . . .

Dr. Byron Merkel, Des Moines, was guest speaker at recent meeting of Nevada Rotary Club. Dr. Merkel is chairman of IMS Medical Manpower Committee. He discussed medical practice opportunities in Iowa. . . . **Dr. H. M. Hurevitz,** Davenport, spoke at recent meeting of Scott County Chapter, American Association of Medical Assistants. . . . **Dr. W. E. Walsh,** West Union, recently received plaque noting his years of service as West Union's North High School team physician. Dr. Walsh has served in this capacity since 1958. . . . **Dr. Lawrence T. Donovan,** pathologist at Holy Family Hospital in Estherville, recently moderated community health education program at Iowa Lakes Community College. Program concerned venereal disease and what to do about it. . . . **Dr. Robert Guthrie,** Iowa City, was guest speaker at annual meeting of Schoitz Memorial Hospital Auxiliary in Waterloo. Dr. Guthrie's topic was "Advances in Radiation Therapy." . . .

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Morbidity Report for November 1972

Diseases	Nov. 1972	1972 to Date	1971 to Date	Most November Cases Reported From These Counties
Brucellosis	2	28	24	Cherokee, Linn
Chickenpox	1095	7860	5691	Clayton, Delaware, Dubuque, Linn, Polk
Conjunctivitis	73	773	397	Buchanan, Jackson, Kossuth
Encephalitis				
Viral	5	12	4	Linn, Winneshiek, Woodbury
Type unspecified	1	6		Woodbury
Gastrointestinal viral infection	712	5672	6366	Buchanan, Floyd, Jackson, Johnson
German measles	28	427	700	Clay, Des Moines, Floyd, Polk
Gonorrhea	602	5645	4868	Black Hawk, Linn, Polk, Woodbury
Histoplasmosis	1	23	16	Mahaska
Impetigo	93	477	434	Hancock, Johnson
Infectious mononucleosis	124	961	891	Johnson, Linn, Polk
Hepatitis				
Infectious	17	275	257	Dallas, Johnson, Polk
Serum	2	50		Johnson, Marion
Measles	111	864	2361	Floyd, Linn
Meningitis				
Meningococcal	1	5	13	Bremer
Viral	3	17	6	Linn, Woodbury
Mumps	542	6525	3673	Floyd, Polk, Warren
Pneumonia	86	863	719	Pottawattamie, Scott
Poliomyelitis, vaccine associated	1	1		Polk
Rabies in animals	29	381	208	Scattered
Ringworm, body	21	98	121	Scattered
Salmonellosis				
S. typhimurium	12	79	42	Scattered
S. agona	2	8		Harrison, Linn
S. enteritidis	2	22	11	Pottawattamie, Davis
S. senftenberg	1	2		Polk
Shigellosis				
S. sonnei	34	287	159	Dubuque, Linn, Polk, Pottawattamie
S. flexneri	2	9		Polk, Scott
Streptococcal infections	624	6283	5585	Johnson
Syphilis	38	442	516	Black Hawk, Polk
Tuberculosis, active	18	113	114	Linn, Polk
Whooping cough	2	42	58	Polk, Woodbury
Chancroid	1	7		Cerro Gordo
Scabies	1	1		Louisa

Dr. R. J. Bealka, Independence, was guest speaker at recent meeting of community's St. John Home and School organization. Dr. Bealka's topic was "Why Do You Want to Be a Bad Parent?" . . . **Dr. Ralph Edwards,** Centerville physician for 36 years, has retired from medical practice. Except for World War II military service, Dr. Edwards has continuously served the citizens of Centerville. . . . **Dr. William L. Buhrow** has joined Clinton's Bluff Medical Center to practice general surgery. A Waterloo native, Dr. Buhrow received M.D. degree from The U. of I., completed internship at Letterman General Hospital in San Francisco, and served a surgical residency at Walter Reed Hospital in Washington, D. C. Dr. Buhrow has been chief of general surgery department at U. S. Army Hospital in Camp Zama, Japan, for two years. . . . **Dr. A. Reas Anneberg,** Carroll, was guest speaker at recent meeting of Carroll Rotary Club. Dr. Anneberg discussed accidents involving children and physical child abuse. . . .

Dr. Chester McClure, psychiatrist at the Northeast Iowa Mental Health Center in Decorah, was guest speaker at recent meeting of Winneshiek County Diabetes Organization. Dr. McClure described relationship between diabetes and mental health, he also explained program of the Mental Health Center. . . . **Dr. Daniel J. Cole** has joined **Dr. John Kelly** in Fort Dodge. Dr. Cole received M.D. degree at Creighton University School of Medicine and interned at St. Joseph's Hospital in Omaha. . . . **Dr. William Owen,** of St. Ansgar, is spending two months in Vietnam under the AMA volunteer physician program. This is Dr. Owen's third Vietnam trip. He served before in Mekong Delta (1966) and at Quang Naig (1969). Dr. Owen also has had two tours of volunteer work in Honduras, the latest in March, 1972, with his son, **Dr. William R. Owen,** who is interning in Johnstown, Pennsylvania. . . .

Dr. George B. Hogenson, Eagle Grove, has been appointed medical service chairman for Wright County Chapter of American Cancer Society. Dr. Hogenson succeeds **Dr. S. P. Leinbach,** Belmond, who organized Wright County Chapter 25 years ago. . . . **Dr. Jack Moyers,** professor and head of Anesthesia Department at The U. of I., is member of new committee

created by National Society of Anesthesiologists to study acupuncture. . . . **Dr. F. O. W. Voigt,** Oskaloosa, and **Dr. William R. Wilson,** Iowa City, were delegates to 1972 annual meeting of American Heart Association in Dallas. **Dr. Dale A. Harding,** Eagle Grove, was an alternate delegate. . . . **Dr. Charles V. Anderson,** associate professor in The U. of I. Departments of Otolaryngology and Maxillofacial Surgery and Speech Pathology and Audiology, is new president of the Iowa Speech and Hearing Association. . . .

Four U. of I. medical faculty participated in December national scientific meetings in Florida. **Dr. Richard M. Caplan,** professor of dermatology, conducted a seminar on "Use of Instruction Objectives in Teaching Dermatology," at meeting of Division of Education of National Program for Dermatology. **Dr. William Fritsch,** associate professor of dermatology, was a seminar participant. **Drs. Christian Radcliffe,** professor of dermatology and **Larry Cole,** resident in dermatology, presented their exhibit at meeting of American Academy of Dermatology. Exhibit demonstrates use of various electrical current modalities in surgery of benign skin lesions, precancerous skin problems and various skin cancers. Dr. Caplan directed a discussion of "Peer Review in Your Office," during the AAD meeting. . . . **Dr. Henry J. Caes,** director, Pathology Laboratory, St. Joseph's Mercy Hospital, Sioux City, has been appointed Clinical Professor of Pathology at the Creighton University School of Medicine in Omaha. Dr. Caes has been clinical associate professor at the school for 13 years. In Sioux City since 1959, Dr. Caes was previously on the faculty of the New York Medical School. He will continue to reside in Sioux City and commute to Omaha. . . .

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DEATHS

Dr. Leon H. Schafer, 71, a DeWitt physician for 32 years, died at his home November 8. Dr. Schaefer was the first president of the staff of DeWitt Community Hospital. He was a member of the Clinton County Medical Society, Iowa Medical Society, American Medical Association and American Academy of Family Practice.

Dr. William E. Ash, 82, died November 8 at Council Bluffs where he had practiced medicine since 1915. A 1913 graduate of the Creighton Medical School in Omaha, Dr. Ash served an internship at Mercy Hospital in Council Bluffs and completed postgraduate work in New York City. He was certified in neurology and psychiatry in 1920. He had served on the staff of Mercy Hospital since 1913 and was a founder of the Council Bluffs Clinic. Dr. Ash was a Fellow of the American College of Physicians and the American College of Neurologists. He was a member of the Central Neuropsychiatric Association, American Medical Association, Iowa Medical Society, Pottawattamie-Mills County Society, Sioux Valley Medical Association and served at one time on the Iowa Board of Medical Examiners. He served on the staff of Jennie Edmundson Hospital in Council Bluffs, and St. Catherine's and St. Joseph's Hospital in Omaha, Nebraska.

Dr. J. C. Peterson, 57, of Hartley, and his wife, Neva, were killed November 11 in an automobile collision on Interstate 80. A 1941 graduate of The U. of I. College of Medicine, Dr. Peterson completed his internship at Duluth, Minnesota. He had practiced medicine at Hartley for 30 years. Dr. Peterson was a member of the O'Brien County Medical Society, the Blue Shield Board of Directors, the Iowa Medical Society and American Medical Association.

Dr. Glenn Dalbey, 55, of Traer, died November 27 at Allen Memorial Hospital in Waterloo of complications suffered in an automobile crash in December, 1971. Dr. Dalbey received the M.D. degree at The U. of I. College of Medicine in 1940. He was a member of the Tama County Medical Society, Iowa Medical Society and American Medical Association.

Dr. W. E. Bullock, 101, died November 13 at the Lake Haven Nursing Home in Minnesota. A Lake Park, Iowa, physician for 60 years, Dr. Bullock received the M.D. degree at The U. of I. College of Medicine in 1901. On his 100th birthday last year, the Lake Park Chamber of Commerce honored Dr. Bullock with an "Honorary Citizen Award." He was a life member of the Iowa Medical Society and American Medical Association.

Dr. James F. Gerken, 74, of Waterloo, died November 29 at St. Francis Hospital. A 1921 graduate of The U. of I. College of Medicine, Dr. Gerken took his postgraduate work at Johns Hopkins University in Baltimore, Maryland, and began his practice of medicine in Waterloo in 1925. He was a member and past president of the Black Hawk County Medical Society and a life member of the Iowa Medical Society and American Medical Association.

Dr. Clarence A. Johnson, 74, of Coon Rapids, died at Arcata, California, on November 22. Dr. Johnson received the M.D. degree at the University of Illinois School of Medicine in 1927 and practiced medicine in Coon Rapids for more than 30 years. He was a member of the Carroll County Medical Society, Iowa Medical Society, and American Medical Association.

Dr. Ernest J. Voigt, 79, a Burlington physician for 39 years, died at Klein Memorial Hospital in Burlington November 8. A graduate of The U. of I. College of Medicine, Dr. Voigt served his internship at University Hospitals in Iowa City. He began his practice of medicine in Burlington in 1919. Dr. Voigt was a member of the Des Moines County Medical Society, Iowa Medical Society and American Medical Association.

Dr. D. F. Miller, 65, of Williamsburg, died November 23 at a Cedar Rapids hospital. A graduate of Northwestern University College of Medicine, Dr. Miller had practiced medicine in Williamsburg for 32 years. He was a past president of the Iowa County Medical Society and had served since 1958 as president of the Williamsburg Community School Board. Dr. Miller was a member of the Iowa Medical Society and American Medical Association.

Physicians' Directory

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Medical Assistants

by TENORA MEYER, CMA

1973 GOALS

Let's increase our membership in 1973. As medical assistants we recognize the purpose AAMA fulfills. AAMA benefits include: (1) continuing education; (2) study programs; (3) opportunity for certification; (4) bi-monthly journal; (5) loan and scholarship programs; (6) professional prestige; (7) group insurance; (8) fellowship; (9) direction to good public relations.

TO THE PHYSICIAN: Is your medical assistant keeping pace with today's advances? Let AAMA help her be a more valuable member of your team. The non-profit AAMA is organized for educational purposes. It is not nor shall it ever become a trade union or collective bargaining agency. Its goals are: (1) To inspire its members to give honest, loyal and efficient service to the profession and to the public which they serve; (2) to strive at all times to cooperate with the medical profession in improving public relations; (3) to provide educational services to increase the knowledge and professionalism of its members and to stimulate a feeling of fellowship and cooperation among the state societies and local chapters.

At present, Iowa has seven chapters:

1. **Mason City**—*President: Frances Jenkins, 215 No. Adams, Mason City, Iowa*
2. **Des Moines**—*President: Diane Day, 1164 Americana Court, Apt. B-3, Des Moines, Iowa*
3. **Davenport**—*President: Jean Gold, 1825 West 40th St., Apt. 7, Davenport, Iowa*
4. **Sioux City**—*President: Dalia O'Connor, 2001 Summit St., Apt. 103, Sioux City, Iowa*
5. **Cedar Rapids**—*President: Sally Mead, 311 22nd St. N.E., Cedar Rapids, Iowa*
6. **Waterloo**—*President: Judeine Matthiesen, 601 Fayette St., Denver, Iowa*
7. **Council Bluffs**—*President: Ina Stancliffe, 429 Ridge Road, Council Bluffs, Iowa*

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

CERTIFICATION: The certification program was instituted in 1961. The importance of being recognized is widely accepted and AAMA certification affords the medical assistant a means of achieving recognition. Thirteen Iowans passed the certification test in June, 1972. Seven of the successful candidates are shown at certification ceremonies October 18, 1972, at the Phoenix convention.



NEWLY CERTIFIED—Left to right: Charlotte Lewis, Waterloo; Tenora Meyer, Mason City; Frances Hansen, Sioux City; Sherry Chidester, Des Moines; Winnie Donovan, Sioux City; Jeanne Green, Davenport; Marylee Dickson, Mt. Pleasant. Not pictured: Barbara Andrews, Council Bluffs; Donna Lee Haney, Des Moines; Betty Lou Kelly, Council Bluffs; Mary Kay McGrain, Des Moines; Patricia Madsen, Council Bluffs; Janet Martin, Des Moines.

OUR GOAL FOR 1973 IS FIFTY?

CONVENTION AND WORKSHOP ATTENDANCE: Each of us should strive to attend at least one convention or workshop. The 1973 state convention will be in Des Moines, May 4-6 at the Holiday Inn. The October national convention will be at the Shoreham Hotel in Washington, D. C.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page



Active members (1973 dues paid) of the Iowa Medical Society: We thank you! We appreciate the support of Iowa medicine which your membership represents.

The 1973 dues payment period continues. We know those physicians who remain outside the Society fold have their well-intentioned reasons. We'll try to respond honestly to any concerns, given the chance.

As has oft been said about any organization, there'll always be areas of disagreement. We know this, we accept it, and we work hard at minimizing them. We feel obviously however that disagreement is best resolved or compromised from within the organization.

We are exhilarated by the events of recent days and months. Today's health care picture may not correspond with our specific blueprint, even so a positive, up-beat outlook sure beats the negative, downtrodden point-of-view. The creation of the Foundation, the modernization of the Annual Meeting schedule, the new committee proposal on reapportionment of the House of Delegates, these are testimony to the Society's desire to be in step with the times. These and other changes will be decided and implemented by those of you interested and dedicated enough to be involved.

We can do much more together. Be assured the Society wants, needs and appreciates your support.

K. E. Lister, MD

K. E. Lister, President

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IOWA Medical Miscellany

HMO PROPOSAL . . . Out of the HMO Study Committee and into new legislative hopper has gone a bill to establish and regulate health maintenance organizations. 24-page bill draft underwent final pre-Assembly pruning at January 4 Study Committee meeting. Proposal overrides legal barriers which now prohibit employment of physicians (makes employment and contractual arrangements optional), and which now prohibit solicitation or advertising by health professionals. Bill appears likely to be most significant state health issue in recent years. IMS will follow developments closely.

SAFE TRANSPORTATION . . . State Safety Commissioner Michael Sellers conferred January 11 with the IMS Committee on Safe Transportation.

CALL FOR NOMINEES . . . January IMS News Bulletin invites individual physicians or county societies to submit names of potential 1973-74 candidates to appropriate district councilor. Mailing advised of offices to be filled and tentative March 25 meeting date of IMS Nominating Committee.

ABOUT OSHA . . . *Physician's Guide to the Occupational Safety and Health Act of 1970* devised by AMA was sent in January by IMS Committee on Industrial Health to county society presidents. Additional copies may be obtained. Committee also offered to assist societies in arranging educational programs on OSHA.

SEEK SPONSORS . . . For second year county medical societies have been invited to sponsor participation by local youth in a summer workshop on chemical substances and other addictions. Invitation has gone to county society presidents from IMS Committee on Alcoholism. Last year 25 youth participated under medical auspices.

NO HMO PLANS . . . January IMS News Bulletin quoted Society President Lister and Foundation President Sunderbruch as saying Iowa Foundation for Medical Care has no plan whatsoever to seek HMO status. Foundation was described as mechanism to provide creative, informed and efficient medical backing to specific delivery programs. Bulletin also enclosed new Foundation informational folder.

CHIROPRACTORS . . . Active effort is being made by Iowa chiropractors to gain lawmaker support for revamping of practice act under which chiropractors now work. Again, IMS will follow developments.

REFRESHER COURSE . . . Four-day Family Physician Refresher Course will run February 13-16 at the Iowa Memorial Union in Iowa City. Sponsors are Department of Family Practice and Office of Continuing Medical Education at The U. of I. and the Iowa Academy of Family Physicians. Potpourri of learning opportunity is scheduled carrying 29 hours of AAFP credit.

HONOR LAWMAKERS . . . Iowa's legislators were honored February 1 at special dinner given by Iowa Health Council. Council has nine member organizations including Iowa Medical Society.

PARAMEDICAL MATTERS . . . Society's Committee on Delegation of Authority met January 18 with representatives of Iowa Nurses' Association and Board of Nursing to continue discussion of paramedical subjects. A. W. Horsley, M.D., U. of I. Assistant Dean for Community Health Care and Allied Health Programs, reviewed new physician's assistant training program.

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THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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FEBRUARY 1973

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The Question Box



By ROBERT E. RAKEL, M.D.

THE QUESTION BOX directs four inquiries to Robert E. Rakel, M.D., about the Family Practice Department which he heads at The University of Iowa College of Medicine.

How would you characterize the Family Practice Department at this point in time?

In the two years since the inception of the Department we have accomplished much.

1. An approved residency program has been developed in Iowa City which will contain 30 residents when fully operational. Four residents—two first and two second year have been accepted during this first year of operation. This will increase to 15 residents July 1.
2. Affiliations have been established with Mercy Hospital, Iowa City; Broadlawns Polk County Hospital, Des Moines and St. Joseph-Mercy Hospital, Mason City. Another is being developed with Iowa Lutheran Hospital, Des Moines.
3. An outstanding Family Practice Model Office has been established on the Oakdale Campus and is fully operational utilizing modern equipment and advanced medical record techniques plus a full allied health team.
4. Undergraduate teaching responsibilities have been established involving medical students at each level of the 4-year curriculum.
5. An active research program is underway involving modernization of the medical record and developing methods for assisting family physicians to evaluate their quality of care.

How many physicians have been appointed in the Department? Are you pleased with this number?

The strength of the Department lies in the outstanding faculty we have been able to recruit. The six full-time and two part-time family physicians have an average of 18 years experience as practicing family physicians. One pediatrician holds a joint appointment with the Department of Pediatrics. This number is adequate for our present stage of development and will hopefully double in the next 3 years.

Can you briefly describe the Family Practice Residency Program?

The Family Practice Residency Program is intended to produce physicians skilled in providing continuing comprehensive care to patients and their families. It consists of three years of postgraduate study, with 10 residents each year. Upon completion the resident is eligible for examination leading to certification by the American Board of Family Practice. Approximately one-third of the time is devoted to experience in the Family Practice Model Office and learning the out-patient skills involved in continuing comprehensive care. Another one-third is elective in nature, allowing each resident to tailor his education to his particular areas of interest once the required core (the final third) has been satisfied.

Does the Iowa Family Practice Program compare favorably with those in other states?

How can I answer this without bias? I feel the Family Practice Residency Programs now underway in Iowa are better than the great majority elsewhere in this country and I have visited many of these in the past four years.

How can Iowa physicians best be supportive of the Family Practice Programs?

Send money. More seriously, by continuing to support and participate in our student programs such as MECO, the preceptorships and by teaching in one of the residency programs on a volunteer basis if one is available.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

WHO TEACHES WHOM?

Visit any classroom (kindergarten through high school) and you'll rarely find the teacher lecturing 50 minutes—or even 30—or 20. Young people are set at problem-solving exercises, or reading assignments, or group projects, or field trips, or. . . . In contrast, most college courses, including the early days of medical school, are long on lecture. American medical education 70 or 80 years ago began to accept learning by doing, by active involvement and active sharing in the management of real patient problems. We structure intern and residency education almost entirely in this active, bedside fashion.

A physician enters practice and continues to learn by active, participatory techniques—we use such names as trial and error, curbstone or koffee klatsch consultations, formal referrals. Most still take some non-interactive presentations in their educational diet, e.g., reading books and journals, listening to audio-tapes, or still newer packages such as slide-sound lectures and television tapes. Programmed instruction and erasure-style patient management problems offer the learner new and more active involvement in the didactic experience.

Put for all the progress of bedside-teaching and its implications about active involvement of the learner, we discover, on viewing the great bulk of formal courses in medical continuing education, they are still largely passive didactic lectures. If they are brief, that helps. If they are presented by a master showman-presenter, so much the better. But where is the involvement of the learner? Fortunately, increasing numbers of meetings now include small-discussion groups, informal q-and-a sessions with participating faculty, self-assessment quizzes or displays. A few even involve actual contact with real problems using patients in clinics, offices, or hospital beds, or workshop simulations such as suture techniques on pig's feet, or pelvic exams on plastic mannequins.

But a great reservoir of potential teaching/learning lies in the vast actual experience accumulated by those who register at continuing education "courses." Any one of the registrants at a course has "pearls" to relate, or with appropriate notice could even make a fine brief didactic presentation, although contributing via informal give-and-take is much more comfortable and successful. If the "instructor" is so identified, if he stands while others sit, and if he holds chalk or pointer, then he not only dominates but he fails to learn from the great accumulation of experience in his presence.

My own conception, then, of *optimum* continuing education involves a maximum of activity (vs. passivity) for the learner, ample opportunity for interchange of ideas among the participants, lots of emphasis on problems that matter most (by virtue of frequency, morbidity and difficulty of management), a mixture of learning methods to maintain interest and acknowledge the variability in individual learning styles, and finally, a maximum of reality *by dealing with the actual problems and the very patients one treats in one's own office or hospital.* This last point emphasizes the immense contribution to continuing education that can come from the new thrust in the study of practice behavior, whether it be called medical audit, peer review, medical care evaluation studies, or whatever. It will permit us all to learn much more effectively from each other.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

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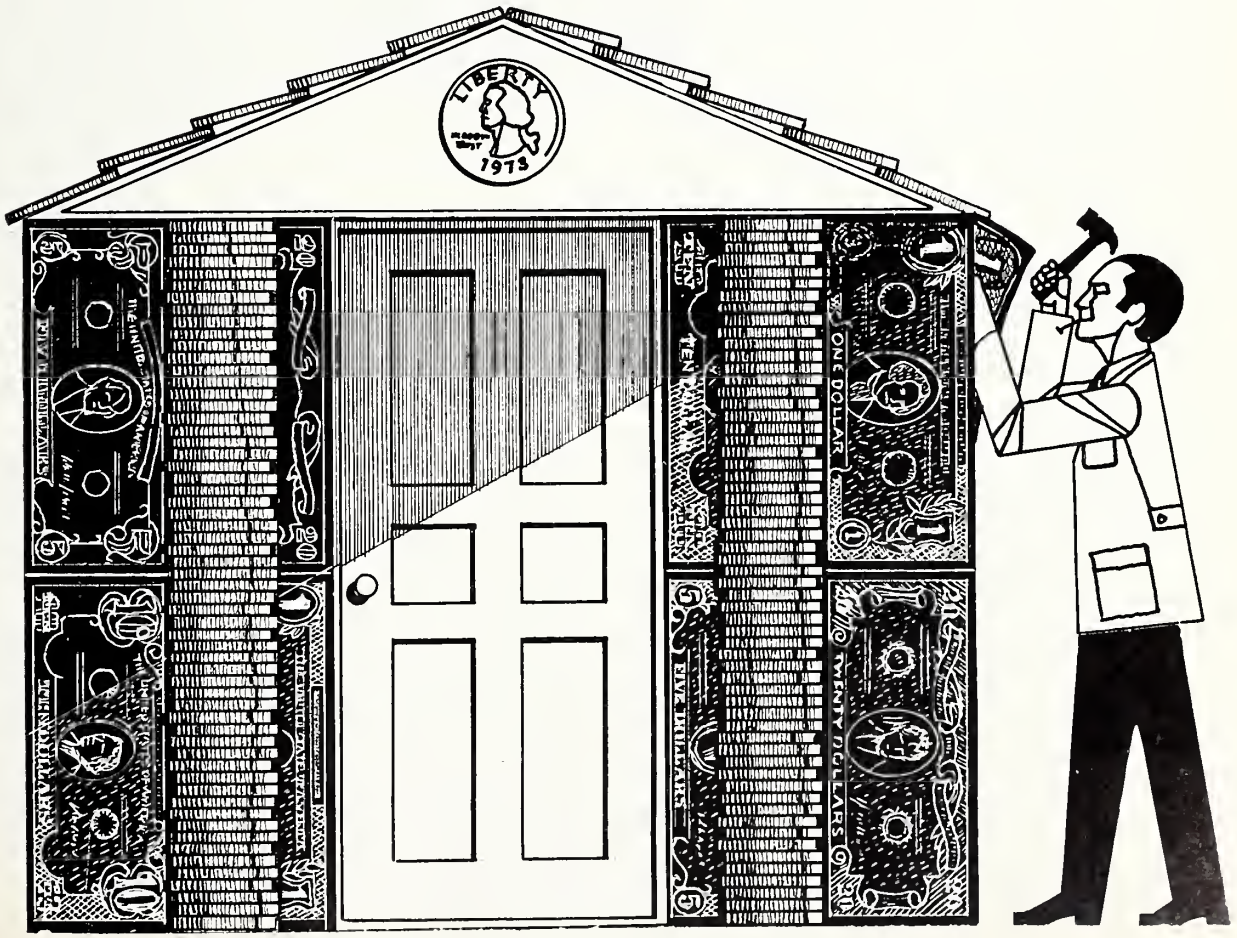
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State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

NEW RECOMMENDATIONS FOR SIMULTANEOUS ADMINISTRATION OF LIVE VIRUS VACCINES

In its 1972 revision of recommended immunization practices (Supplement to Morbidity and Mortality Weekly Report, June 24, 1972), the U. S. Public Health Service Advisory Committee on Immunization Practices noted that, "Recently licensed combination live virus vaccines (measles-mumps-rubella, measles-rubella, and rubella-mumps), incorporate specific vaccine virus strains of demonstrated effectiveness and safety when administered simultaneously. Combinations of one manufacturer's measles vaccine with other manufacturers' mumps and rubella vaccines have not been tested sufficiently to recommend their simultaneous administration at this time."

In the November 27, 1972 issue of the Morbidity and Mortality Weekly Report, the Advisory Committee amended its recommendations in two significant ways—to support simultaneous administration of measles and rubella vaccines from different manufacturers, and to support the simultaneous administration of the licensed measles-mumps-rubella (MMR) combination vaccine along with trivalent oral polio vaccine (TOPV). The text of that recommendation follows:

RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

SIMULTANEOUS ADMINISTRATION OF CERTAIN LIVE VIRUS VACCINES

Supplementary Recommendation

Recently acquired data on simultaneous administration of certain live virus vaccines provided a scientific basis for using them together when desirable in preventive medicine programs.

MEASLES AND RUBELLA VACCINES

Licensed combinations of live virus vaccines (measles-mumps-rubella, measles-rubella, and rubella-mumps) have already been recommended for use (Supplement, MMWR Vol. 21, No. 25). At the time of that recommendation, there were insufficient data to comment on giving other manufacturers' strains of measles and rubella vaccines together. Recent clinical trials indicate that the Schwartz strain of measles vaccine and the Cendehill strain of rubella vaccine can be safely and effectively administered at the same time at separate sites.

MEASLES-MUMPS-RUBELLA AND ORAL POLIOMYELITIS VACCINES

It has been recommended that measles and rubella vaccines and the third dose of trivalent oral poliomyelitis vaccine (OPV) be administered during the second year of life. Newly acquired serologic evidence shows that when the licensed combination measles-mumps-rubella vaccine is given simultaneously with trivalent OPV, antibody responses can be expected to be comparable to those which follow administration of the vaccines at different times.

The Immunization Branch of the State and Community Services Division, Epidemiology Program, Center for Disease Control, has gone

(Continued on page 52)

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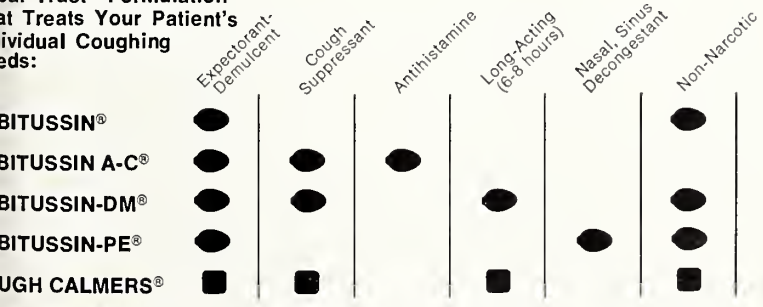
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STATE DEPARTMENT OF HEALTH

(Continued from page 50)

one additional step in advising that in addition to the MMR, either single measles or rubella vaccine, or the M-R combination, may be administered simultaneously with TOPV. The rationale is that children should respond at least as adequately to fewer of the same antigens in combination, as they do to the MMR-TOPV combination.

This information should give the practicing physician greater flexibility in his choice of vaccines, relative to providing ideal and specific immunization at lowest cost and fewest visits for the individual patient concerned.

Morbidity Report for December, 1972

Diseases	Dec. 1972	1972 to Date	1971 to Date	Most December Cases Reported From These Counties
Amebiasis	5	5	4	Dallas, Davis, Johnson, Keokuk, Polk
Bacterial-				
Haemophilus parainfluenzae	1	1	0	Polk
Brucellosis	1	29	30	Crawford
Chickenpox	1590	9450	7171	Des Moines, Polk, Pottawattamie
Conjunctivitis	102	875	529	Bremer, Crawford
Eaton's				
Agent Infection	5	5	0	Aubudon, Black Hawk, Fayette
Encephalitis				
type unspecified	3	9	2	Jackson, Scott, Story
viral	3	15	5	Clay, Johnson, Davis
associated with mumps	2	2	0	Johnson
associated with ECHO 11	1	1	0	Linn
German Measles	37	464	751	Scattered
Gastrointestinal viral infection	2389	8061	8953	Jackson, Pocahontas, Polk
Gonorrhea	552	6197	6115	Scattered
Hepatitis, serum	1	51	13	Johnson
infectious	18	293	303	Polk
viral type unspecified	1	1	0	Scott
	1	1	0	Poweshiek
Histoplasmosis	3	26	21	Jefferson, Jones, Polk
Impetigo	52	529	596	Cedar, Humboldt
Infectious mononucleosis	61	1022	1083	Linn, Scott
Influenza—				
lab confirmed	1	64	24	Warren
Influenza-like illness	655	655	0	Scattered
Measles	250	1114	2717	Floyd, Linn, Poweshiek
Meningitis				
type unspecified	12	32	16	Des Moines, Scott, Linn
associated with Coxsackie A4	1	1		Johnson
Meningo-encephalitis	3	9	6	Johnson, Polk
Mumps	461	6986	5750	Scattered
Pediculosis	21	21		Washington, Woodbury
Pneumonia	149	1012	921	Buena Vista, Pottawattamie, Scott
Rabies in Animals	19	350	240	Scattered
Rheumatic fever	3	32	57	Linn, Pottawattamie, Woodbury
Ringworm, body	15	113	161	Pottawattamie
Scabies	2	2		Louisa, Black Hawk
Salmonellosis				
S. agona	2	10		Black Hawk, Dubuque
S. thompson	2	2	27	Scott
S. typhimurium	3	82	52	Dallas, Fayette, Mills
Shigellosis				
S. sonnei	274	561	200	Van Buren
Streptococcal infections	508	6791	6758	Johnson
Syphilis	54	496	601	Polk, Scott
Toxoplasmosis	1	3	0	Polk
Tuberculosis, active	4	117	129	Keokuk, Madison, Polk, Union
Tuberculosis, inactive	1	21	25	Linn
Whooping cough	33	75	79	Buchanan

University Drug Letter

by S. FRED BRUNK, M.D.

ANTITUSSIVE AGENTS

Cough, as a protective reflex, helps rid the lower respiratory tract of secretions and foreign material. It is also, however, a common symptom of disease of varied etiology. Diagnosis and treatment of any underlying disease remains the most specific treatment. Cough secondary to acute upper respiratory infection or irritation may be expected to subside spontaneously within a few days and may not require treatment. When symptomatic treatment is felt indicated, management may be made easier if the source of the peripheral stimulus to cough can be determined. Cough which arises from irritation of the mucosa of the pharynx may often be satisfactorily managed with pharyngeal demulcents and local sialogogues. If the cough is nonproductive or the sputum tenacious, an agent which increases the secretion of respiratory tract fluid may be of value. Severe cough may require treatment with the more specific antitussive agents which suppress cough. The goal in the symptomatic treatment of cough is to decrease frequency and intensity of cough while still permitting adequate elimination of secretions from the tracheobronchial tree.[3]

Cough is both an objective and a subjective phenomenon. An antitussive agent may affect one or both of these aspects. Symptomatic (cough) relief and symptom (cough) suppression need not necessarily occur together and indeed frequently do not. Antitussive agents unquestionably provide symptomatic relief to patients with cough. This subjective effect is shown rather consistently with samples of moderate size. These patients may obtain symptomatic relief and subjectively feel that they have reduced frequency and intensity of cough when actually there is no objective change.[1, 5]

The antitussive agents may be divided into two groups: 1) centrally acting antitussive agents, and 2) peripherally acting antitussive agents. The centrally acting group may be subdivided into narcotic antitussives and nonnarcotic antitussives.

Dr. Brunk is an associate professor in The Department of Internal Medicine at The University of Iowa College of Medicine. This discussion has appeared previously in the DRUG LETTER, a monthly intramural publication of University Hospitals, prepared jointly by the Pharmacy Department and the Clinical Pharmacology Committee.

NARCOTIC ANTITUSSIVE AGENTS

Codeine is generally accepted as the most useful antitussive available.[7, 11] *Hydrocodone* (Dicodid) is a slightly more potent antitussive agent than codeine as judged by subjective studies;[3] an objective comparison of relative antitussive potency in patients with chronic cough is not available. The antitussive potency of *ethylmorphine* is felt to be about the same as that of codeine, and it presents no particular advantage as an antitussive agent.[6] *Morphine, methadone* (Dolophine), and *phenazocine* (Priadol) are more potent antitussives but have increased addiction liability.[7] The relative potency of these narcotic antitussives has not been determined by objective clinical studies in patients with chronic cough.

The narcotic antitussives have adverse gastrointestinal effects, and may produce physical and psychogenic dependence. The respiratory depression induced by equianalgesic doses of these agents is roughly comparable in magnitude.[2] At the dosage levels used for antitussive effect, respiratory depression is an infrequent clinical problem.

The usual oral dosages of the narcotic antitussive agents are listed in Table I.[3, 7, 10]

NONNARCOTIC ANTITUSSIVE AGENTS

A number of chemically unrelated nonnarcotic agents have been reported to be useful antitussives. Most of these are reported to act by a relatively selective depression of the central cough mechanism. Most of these nonnarcotic antitussives have been reported to decrease experimentally-induced cough, and most have been reported effective in clinical studies of chronic cough in which subjective evaluations of benefit were made. The clinical evaluation of these agents regarding efficacy and relative potency in general, however, remains incomplete and must await objective clinical studies in patients with chronic cough to determine whether these agents will indeed decrease the frequency and intensity of cough. Objective clinical studies in chronic cough have been reported for *levopropoxyphene napsylate* (Novrad)[8, 13] and *pipazethate* (Theratuss)[9, 12] and no significant suppressive effect was found; these agents have been reported of benefit in subjective studies.

(Please turn to page 80)



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SCIENTIFIC ARTICLES


DR. SCHMIDT


DR. RICHARDS


DR. FREEMAN


DR. CONDON


DR. BONNEY


DR. LAWTON

- **Urinary Tract Infection**
  Joseph D. Schmidt, M.D.
- **Dialysis in Iowa: Questions & Answers**
  Carl J. Richards, M.D.
  Richard M. Freeman, M.D.
- **Acute Renal Failure**
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- **Kidney Transplantation in Iowa**
  William W. Bonney, M.D.
- **Organ Procurement & Preservation**
  Richard L. Lawton, M.D.

1973 Renal Disease Treatment in Iowa

IT IS MOST TIMELY *to present a symposium devoted to both the primary treatment of urinary tract disease and the Iowa chronic renal disease program.*

These are exciting years. In the urinary tract it has been possible for the first time to replace diseased vital organs by an artificial substitute and then by a homograft. Physicians across Iowa are working to make dialysis and transplantation available to suitable patients. The Iowa Renal Disease Commission is now meeting to consider financial support for selected patients. Yet a great deal of research and high quality medical practice is needed to achieve the ultimate goal: the early detection and cure of renal disease.

This symposium coincides with the 1973 Iowa Renal Disease Conferences. Under its first two presidents, Mr. Bud Suter and Dr. Richard Lawton, the Kidney Foundation of Iowa has made rapid advances in support of our renal disease program. The Foundation's goals include the promotion of scientific research, federal and state legislation, and community service. Its Medical Advisory Board has planned a series of educational conferences; these are noted on the schedule which is provided. All physicians are invited to participate.

WILLIAM W. BONNEY, M.D.
Symposium Editor

1973 Renal Disease Conferences

Sponsors: Kidney Foundation of Iowa
Iowa Regional Medical Program
University of Iowa College of Medicine

AAFP
One Hour
Course Credit

The brief conferences listed below will be concentrated on the office and hospital management of urinary tract disease problems. Cost will be limited to refreshments and dinner. All Iowa physicians are invited to participate. For information please contact a conference chairman or the Kidney Foundation office.

Kidney Foundation of Iowa



4910 Urbandale Avenue
Des Moines, Iowa 50310
Phone (515) 274-4791
Mr. John Davis, Director

THE CONFERENCE SCHEDULE

Date & Time	Dinner Meeting Location	Conference Faculty	Chairman's Address	Host Organization
Tuesday, March 6 6:00 p.m.	Davenport Outing Club Brady Street	Dr. Alex Boone, urologist, Davenport (chairman) Dr. Gerald Di Bona, nephrologist, Iowa City	3319 Spring Street Davenport 52807 (319) 359-1641	Scott County Medical Society
Tuesday, March 13 6:30 p.m.	Boone Tick-Tock Restaurant	Dr. Kennedy Fawcett, nephrologist, Ames (chairman) Dr. William Bonney, urologist, Iowa City	McFarland Clinic Ames 50010 (515) 232-4530	Boone and Story Medical Societies
Friday, March 16 7:00 p.m.	Mt. Pleasant Iris Restaurant Highway 34	Dr. Harold Rankin, nephrologist, Mt. Pleasant (chairman) Dr. Charles Hawtrey, urologist, and Dr. Carl Richards, nephrologist, Iowa City	207 S. Harrison Mt. Pleasant (319) 385-3414	Henry County Medical Society
Tuesday, March 20 6:30 p.m.	Council Bluffs Club 64	Dr. Jose Martinez, urologist, Council Bluffs (chairman) Dr. Linda Rames, nephrologist, Iowa City	201 Ridge Street Council Bluffs 51501 (712) 328-2616	Pottawattamie-Mills Medical Society
Thursday, April 19 6:00 p.m.	Sioux City Country Club	Dr. George Spellman, nephrologist, Sioux City (chairman) Dr. Joseph Schmidt, urologist, Iowa City	432 Badgerow Bldg. Sioux City 51100 (712) 258-6586	Woodbury Medical Society
Tuesday, April 24 6:00 p.m.	Waterloo St. Francis Hospital	Dr. Richard Long, urologist, Waterloo (chairman) Dr. Catherine Condon, nephrologist, Des Moines	3116 Kimball Ave. Waterloo 50702 (319) 234-2649	Waterloo Hospital Staffs

Registrants who are not members of the host organization are requested to make prepaid reservations two weeks in advance with the appropriate conference chairman.

Urinary Tract Infection

JOSEPH D. SCHMIDT, M.D.
Iowa City

THE PROBLEM OF URINARY TRACT INFECTION is appropriate for discussion in this symposium on renal disease since infection and its sequelae are a common cause of chronic renal insufficiency and death.[1, 2] In accurately diagnosing and treating urinary tract infections our objectives should include not only the immediate alleviation of pain and suffering and eradication of the infection, but also long-term goals of preservation of renal function and urinary transport. Frequent or persistent episodes of upper urinary infection such as pyelonephritis definitely lead to destruction of functioning nephron units and interfere with the ability of the calyces and renal pelvis to transport urine to the ureters and bladder.

DIAGNOSIS

The accurate diagnosis of urinary tract infection should be based on the finding of bacteria in the microscopic examination of the urine or on a urine culture. Pyuria, the finding of increased numbers of leukocytes in the urine, is only an indirect indicator of urinary infection which reveals urinary tract irritation or inflammation whether it be due to foreign bodies, stones, malignancies, tuberculosis or pyogenic bacterial infection. Considering the use of a clean-catch mid-stream urine specimen for urine culture, a colony count of 100,000 colonies/ml is generally accepted to be diagnostic for urinary infection.[3] However, a colony count of 10,000 colonies/ml may also represent bona fide infection in view of the clinical setting and need not be repeated except in instances of questionable historical data. Bacteriuria (mainly bacilluria) noted on urinalysis is consistent with a colony count of 100,000 colonies/ml and may be sufficient for institution of appropriate treatment. However, urine culture and sensitivity testing are still recommended for exact identification of the infecting organism and its *in vitro* response to various antimicrobials. Although the gram stain is helpful in documenting bacteriuria, this maneuver does not clarify the problem since 95% of urinary tract infections are due to gram-negative bacilli.

PATHOGENESIS

The various portals of urinary infection include 1) hematogenous, 2) lymphogenous, 3) ascending and 4) direct. Studies of serotypes showing that the enteric organisms found in patients' colonic flora are identical to those organisms causing lower urinary tract infection have helped mount evidence for lymphatic spread of bacteria between the gastrointestinal and urinary tracts.

Very common sources of lower urinary tract infection are the female perineum and distal urethra. Studies have shown that coliform bacteria recoverable from the perineum, introitus or distal urethra are identical to the organisms later found in patients harboring symptomatic lower urinary tract infections. Milking of the under surface of the urethra can, by mechanical action alone, allow pathogenic organisms to spread in an ascending fashion into the proximal urethra and bladder where cystitis may then flourish. Chronic bacterial prostatitis has been shown to be the focus for recurrent or relapsing lower urinary tract infections in males. Also ascending infection can occur

Dr. Schmidt is an associate professor in the Department of Urology at The University of Iowa College of Medicine.

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when a patient is treated with an indwelling urethral catheter. The organisms migrate either in the urethral mucus promoted by the foreign body or directly in the catheter and tubing lumen which can be so easily contaminated.

Since the normal urinary tract, including normal bladder emptying capability, will withstand and spontaneously eliminate infecting organisms, in some patients the primary source of the infection is not readily identified. Infections are commonly secondary to problems such as underlying urinary tract obstructions, urinary calculi, foreign bodies and tumors. An overall decrease in systemic and/or local host defense mechanisms may account for those urinary infections which we would otherwise classify as *de novo*. Examples of such defense mechanisms include an intact immune system, an unknown mucosal factor and the bladder's ability to empty itself to within 0.5 ml of urine.[4]

SYMPTOMS AND SIGNS

Certain information gleaned from the history and physical examination may point to the site of urinary infection. Acute pyelonephritis is manifested by fever, chills, malaise and unilateral or bilateral back or fever aching. The patient is ill and may be exquisitely tender over either costovertebral angle. The patient with acute cystitis will instead complain of frequency, dysuria, urgency and perhaps even some urge incontinence, and terminal hematuria. Physical examination may be normal except for some tenderness over the suprapubic area or the urethra. Careful pelvic examination may reveal an associated vaginitis or cervicitis as a cause of, or complication of, recurrent cystitis.

LABORATORY STUDIES

A urinalysis and urine culture should be the initial laboratory investigations. In the male there should be no problem in collecting a clean-catch mid-stream urine free of contamination. In the uncircumcised patient care should be taken to see that the foreskin is retracted and the glans penis well cleaned of any smegma. In the female a clean-catch mid-stream urine is not so easily achieved except with expert patient instruction and cooperation. However, an attempt should be made to collect a proper specimen by this method. In the face of equivocal "clean" voided specimens, or because of possible menstrual contamination, a specimen taken directly via a small catheter using aseptic technique may be more appropriate. In the infant or young child suprapubic aspiration using a small-bore needle gives reliable specimens free of contamination.

A leukocyte count will generally be elevated with a shift to the left in patients with upper tract infections and be normal in those with cystitis. Urinary infections in the male and repetitive infections in the female demand further investigation including determination of renal function such as a BUN and serum creatinine. Urologic investigation includes excretory urography and cystography. The urogram is a crude test of renal function but can outline the anatomy of the urinary tract and detect pathology such as calculi, tumors and obstructions. The cystogram is useful to detect abnormalities such as neurogenic disease, vesicoureteral reflux, diverticula and poor emptying with residual urine. Cystourethroscopy and direct urethral examination may uncover problems such as distal urethral or meatal stenosis, suburethral diverticula, chronic urethritis and skenitis, as well as bladder tumors, stones or acute hemorrhagic cystitis.

TREATMENT

Therapy should be directed against 1) the infecting agent, and 2) the underlying pathology. A whole host of agents are available including antibacterials, sulfonamides and antibiotics. Uncomplicated lower tract infections usually respond quite well to a variety of sulfonamides or nitrofurantoin, while bouts of acute pyelonephritis respond quickly to antibiotics such as ampicillin and tetracyclines. Matching the potential benefits and toxicity of the more potent and costly drugs against the infection and underlying complications is not the subject of this article.

Treatment should be maintained for 10-14 days and, ideally, a urine specimen should be checked by urinalysis and culture after 5 or 7 days of therapy to determine response and again in 2 to 4 weeks to determine whether the response is lasting. Here I might distinguish between re-infection and relapse. Re-infection indicates a second infection due to a different organism, whereas relapse indicates

infection due to the same organism that had previously been eradicated.

It is usually preferable to defer treatment of any underlying pathology until the effects of the acute infection itself are ameliorated. Exceptions include patient with severe infection to the point of sepsis secondary to obstruction of one or both ureters.

UROSEPSIS

Patients developing urinary tract sepsis (bacteremia, septicemia) usually demonstrate certain predisposing factors: underlying chronic disease, advanced age, general debility, or recent urinary tract instrumentation of surgery.[5, 6]

The diagnosis is easily made in such a patient who has a sudden onset of fever, chills, malaise, perhaps some nausea and vomiting, along with tachycardia and drop in blood pressure. Cultures should be taken from appropriate urine and blood samples, but therapy should be instituted immediately rather than wait for results of cultures. The choice of an agent or agents is based on some of the following information: 1) the patient's bacterial flora such as a recent urine culture; 2) the patient's disease process; 3) the current hospital flora causing the majority of cases with urosepsis; 4) the better drugs currently available for urosepsis; and 5) "shotgun" therapy where certain fixed combinations of parenterally-administered antibiotics are given theoretically to "cover" most of the infecting organisms that might be causing the urosepsis. The route of therapy should be intravenous. Surgical drainage is indicated on an emergency basis. Supportive measures such as intravenous fluids, plasma, blood and corticosteroids may be given as needed. Therapy should extend for two weeks; urine and blood cultures should resort to negative in 3 to 7 days with appropriate treatment. Underlying factors should be treated as quickly as possible with regular follow-up urinalyses and urine cultures to detect urinary re-infection or relapse.

OVERVIEW

The wide spectrum of urinary infections is exemplified on one hand by the fairly common "innocent" bout of cystitis experienced by so many parous females, and on the other hand by recurrent and relapsing acute and chronic pyelonephritis ultimately leading to the complete loss of renal parenchyma. In fact unilateral or bilateral vesicoureteral reflux associated with chronic atrophic pyelonephritis[7] has been uncovered as an underlying cause of chronic renal failure in approximately 20% of patients considered for renal transplantation at the University of Iowa Hospitals-Iowa City Veterans Administration Hospital Medical Center.

Constant vigilance in sorting out the "high-risk" group of patients from those who will suffer no deterioration of renal function and urine transport from urinary tract infection is the pressing responsibility of all physicians.

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SET OBSTETRICAL PARLEY

A Conference on the High Risk Obstetrical Patient, Her Fetus and Newborn will occur April 24 and 25 at the Iowa Memorial Union in Iowa City. Advances in perinatal care will be presented for physicians and obstetrical and pediatric nurses.

Co-sponsors of the conference will be the Iowa Regional Medical Program and the Maternal and Child Health Division of the State Department of Health.

Dialysis in Iowa: Questions & Answers

CARL J. RICHARDS, M.D., and
RICHARD M. FREEMAN, M.D.
Iowa City

ONLY IN THE PAST 10 years has hemodialysis become a practical method of managing uremia. In that time, many changes have occurred which have solved problems and created others. The following is a question and answer review of a number of aspects of hemodialysis in Iowa.

SELECTION OF PATIENTS

I. *Question:* Which of the following patients would you refer for evaluation for placement on chronic hemodialysis? Check box if you would refer.

[ ] 1) A 22-year-old female with end stage renal disease due to systemic lupus erythematosus.

[ ] 2) A 42-year-old male with chronic gout and renal failure due to gouty nephropathy.

[ ] 3) A 33-year-old man with juvenile onset diabetes and end stage renal disease due to chronic pyelonephritis.

[ ] 4) A 19-year-old female with chronic glomerulonephritis and a blood pressure of 190/120 mmHg.

[ ] 5) A 51-year-old man with a myocardial infarction 4 years ago and occasional anginal pain with renal disease from chronic pyelonephritis.

[ ] 6) A 23-year-old female with congenital urinary tract obstruction, a damaged bladder and bilateral hydronephrosis.

Dr. Richards is a renal fellow and Dr. Freeman is an associate professor of medicine. Both are associated with The University of Iowa and Veterans Administration dialysis units in Iowa City.

Discussion:

The present criteria for accepting chronic dialysis patients are purely arbitrary and depend on various factors including availability of facilities and personnel, funding, rate of turnover of patients and activity of a transplant program in which dialysis patients are placed. In addition the type of illness contributing to the patients' end stage renal failure must be considered. As long as selection is necessary, the intent is to select those patients most likely to show long term benefit from treatment.

I. *Answers:*

[ ] **1) Systemic Lupus Erythematosus—A patient with a systemic disease which might prove fatal to him is generally not considered a candidate in most institutions including our University-VA dialysis program. Other such conditions include for example, leukemia, lymphoma, metastatic cancer and generally other collagen vascular diseases.**

[X] **2) Chronic Gout—This is an example of a systemic disease which might cause end stage renal failure but whose systemic effects are generally controllable and do not prove life threatening. This patient would prove acceptable in most centers.**

[ ] **3) Diabetes Mellitus—Note that this patient has *juvenile* diabetes which has far reaching, serious systemic extrarenal effects. Such patients tend to do poorly when dialysis is instituted, causing difficulty with control of the diabetes. The adult diabetic without insulin requirement and with few complications is easier to manage but may still have much difficulty on dialysis. Thus, at present (January 1973) diabetes of both types is excluded from the University-VA dialysis program. With better facilities and advances in techniques, the adult diabetic may be more frequently dialyzed. One should avoid labeling a patient "diabetic" because of an abnormal glucose tolerance curve alone. Azotemia induces abnormal glucose handling and almost all azotemic patients will have abnormal glucose tolerance curves without being "diabetic."**

[X] **4) Chronic Glomerulonephritis with hypertension—Many patients on chronic dialysis are**

there as a result of chronic glomerulonephritis and most of them are hypertensive at the start of dialysis. Hypertension does not preclude dialysis so this patient would be accepted, providing the hypertension had not caused serious systemic effects such as marked cardiovascular and central nervous system disease. In most patients the hypertension resolves after excess water and salt are removed. In a minority bilateral nephrectomy must be performed to control the blood pressure.

[ ] 5) Cardiovascular disease—Dialysis induces wide changes in intravascular volume and blood pressure. Arteriovenous fistulas and shunts and the anemia of uremia increase the cardiac output. All place a stress on even a previously healthy heart. Thus, the patient with known coronary artery disease, especially with angina, is not a good candidate for dialysis. As expected, these patients have a high incidence of cardiac side effects when they are receiving hemodialysis.

[X] 6) Lower urinary tract disease—A few years ago these patients were excluded from chronic hemodialysis. Facilities were limited and there was little chance for transplanting a kidney into a diseased lower urinary tract. The difficulty with transplantation still exists today but with better facilities such patients are being accepted into our home dialysis program and into some center programs. These patients are generally younger and thus do better on dialysis than older patients with other diseases.

A dialysis program must of necessity be selective to deliver the most care to the greatest number of patients. Facilities and funding are limited so a program cannot afford to serve patients who have no potential to move out. Turn-over must exist to serve others who need dialysis. With expansion and advancement the above criteria are likely to change.

INDICATIONS FOR DIALYSIS

II. *Question*: Are the following statements true or false? Place a T or F in the box.

[ ] 1) The most rapid method for lowering a dangerously elevated serum potassium is hemodialysis.

[ ] 2) A BUN above 100 mg percent is generally associated with uremic symptoms.

[ ] 3) Fluid can be removed rapidly during hemodialysis and is a very effective way of relieving congestive heart failure due to fluid overload.

II. *Answers:*

[F] 1) This statement is false. Hemodialysis is an effective way of lowering the serum potassium over a few hours time; however, other methods are more rapid, such as intravenous sodium bicarbonate and glucose and insulin. It is true these latter substances cause a redistribution of potassium from blood into cells rather than removing the potassium from the body, but under emergency conditions they are much faster than hemodialysis. The delay in setting up the dialyzer is another limitation in using dialysis as the *first* line of defense against hyperkalemia. Once emergency measures have been started to combat hyperkalemia, hemodialysis can be instituted if indicated. In summary, the following methods for treating a dangerously high serum potassium level are rapid acting: 1) intravenous sodium bicarbonate, 2) intravenous glucose and insulin and 3) intravenous calcium gluconate. Oral or rectal Kayexalate and hemodialysis are also effective but slower acting.

[T] 2) In most patients, a BUN greater than 100 mg percent is associated with symptoms, especially nausea and vomiting. However, there are some patients with a BUN above 100 mg percent who do not develop symptoms. The blood urea itself is generally not considered harmful, but other factors, many of them unidentified, can cause problems. These include: 1) bleeding, usually noticed first in the gastrointestinal tract, 2) pericarditis, which may be complicated by cardiac tamponade and 3) a progressive peripheral neuropathy, usually associated with long-standing uremia. All of these are indications to begin hemodialysis.

[T] 3) This statement is true. The cause of congestive failure is failure to excrete the excess salt and water that are ingested. Fluid overload responds nicely to hemodialysis. Other causes of heart failure include myocardial or coronary artery disease which may respond less well to dialysis and cardiac tamponade from uremic pericarditis.

Discussion:

The indications for chronic hemodialysis of a renal failure patient are therefore: 1) BUN greater than 100 mg percent in a symptomatic patient, 2) bleeding, 3) pericarditis, 4) neuropathy, 5) uncontrolled hyperkalemia, and 6) uncontrolled fluid overload and congestive heart failure.

In addition the patient with acute renal failure, which is expected to resolve within three to four weeks, will be supported with intermittent hemodialysis over the duration of his azotemia. Another indication for short-term dialysis is a poisoning amenable to removal by dialysis.

The patient with chronic uremia is usually managed conservatively without dialysis for as long as possible. The decision when to start

the patient on hemodialysis to avoid the above named complications is not always an easy one but the occurrence of any of them is indication to start chronic dialysis.

UREMIA AND DIALYSIS PROBLEMS

III. *Question:* Below is a list of conditions. Check items in the first column you would expect in the uremic patient who has not been dialyzed in contrast to the patient in the second column who has been on twice-weekly dialysis for one year.

Condition	*Uremia Before Dialysis*	*After 1 Yr. on Dialysis*
1. Anemia	—	—
2. Bleeding	—	—
3. Fractures	—	—
4. Hypertension ..	—	—
5. Acidosis	—	—
6. Neuropathy ...	—	—
7. Infection	—	—
8. Hyperphosphatemia	—	—
9. Dietary sodium restriction	—	—

III. *Answers:*

[X, X] **1) Anemia is a problem of varying degree in uremia with hematocrits of generally between 10 and 25 vol. percent. It is due to several factors: a) decreased bone marrow stimulation resulting from a decreased production of erythropoietin, a marrow stimulating hormone produced in the kidney, b) shortened red cell survival with a tendency toward hemolysis and c) iron deficiency from blood loss. Hemodialysis does not correct the anemia and can contribute to it from blood loss during dialysis and diagnostic phlebotomy.**

[X, X] **2) Bleeding occurs in uremia in part due to inhibition of platelet aggregation by factors unknown. It may be mild, in the form of gastrointestinal oozing, or marked, with fatal hemorrhage. This type of bleeding is usually corrected by intensive dialysis. After the patient's uremia is brought under better control with dialysis he may still bleed, but for other reasons. Bleeding is usually a result of the anticoagulant used during dialysis in this situation. This may be remedied by intravenous protamine sulfate but serious bleeding does occur.**

[X, X] **3) Fractures. Uremic bone disease occurs after long standing uremia and is thought to be related in part to excessive parathyroid hormone secretion resulting from abnormal serum calcium and phosphate levels. Before hemodialysis was available, patients generally did not live long enough to develop bone disease. However, the longevity induced by dialysis has allowed time for the development of bone disease which is now much more common and is likely to result in fractures of ribs and long bones.**

[X,] **4) Hypertension. Most patients beginning dialysis are hypertensive from salt and fluid overload. This is rapidly corrected by dietary restriction and dialysis. However, a small percentage of patients will remain hypertensive despite marked reduction in body salt and water. This is related to elevated circulating renin levels and, if not adequately controlled with medication, may respond to bilateral nephrectomy.**

[X,] **5) Acidosis. Metabolic acidosis in the uremic patient results from an inability to excrete the acid sulfates and phosphates normally present in the diet. It is usually well tolerated on a chronic basis. Once started on hemodialysis the acidosis is generally corrected with blood pH's near normal.**

[X, X] **6) Neuropathy with complaints ranging from burning of the feet to weakness and frank foot drop is fairly common with the long standing uremic patient. Extended hours of dialysis will usually effect an improvement but rarely eliminates it.**

[X, X] **7) Infection. Uremic patients have impaired cellular immunity and are prone to viral and fungal infections. Antibody formation is generally less affected but bacterial infections are not uncommon with pulmonary and urinary tract infection being the most common. Infection in the dialysis patient commonly involves arteriovenous shunts at the site of exit from the skin and may result in septicemia and septic emboli.**

[X, X] **8) Hyperphosphatemia commonly seen in the uremic patient is usually still present after dialysis. For this reason dialysis patients must continue to take amphogel to control serum phosphate levels. The hyperphosphatemia is usually associated with a hypocalcemia in the non-dialyzed patient.**

[X, X] **9) Dietary Sodium Restriction is imposed on most azotemic patients when their ability to excrete sodium diminishes to a degree wherein they cannot excrete the normal daily dietary sodium load (above 8 gm NaCl). Dietary sodium restriction is generally continued in the dialysis patient to avoid excessive fluid accumulation resulting in congestive failure or elevated blood pressure.**

IV. *Question:* Please check which of the following may lead to death in patients on chronic dialysis?

[ ] 1) Intracranial bleeding

[ ] 2) Infection

[ ] 3) Bone disease
[ ] 4) Hyperkalemia

IV. *Answers:*

[X] **1) Intracranial bleeding has been a leading cause of death in our patients. Bleeding usually occurs in conjunction with heparin anticoagulation used in dialysis. Patients receiving coumadin to prevent clotting in shunts have also succumbed to intracranial hemorrhage. Pre-disposing causes, such as a cerebral aneurysm which is more common in patients with polycystic kidney disease, are sometimes responsible, but often a direct cause cannot be found.**

[X] **2) Infection is also a cause of death. Pulmonary infections and septicemia from arteriovenous shunts are the usual types of infection although the urinary tract and almost any other area can be involved.**

[ ] **3) Fractures resulting from renal bone disease are not lethal in themselves, but result in immobilization of the patient which leads to further complications including poor appetite, bed sores, pulmonary infection (especially in case of rib fractures) and depression.**

[X] **4) Hyperkalemia has triggered fatal arrhythmias and is usually a result of dietary indiscretion.**

Discussion:

The life of the patient on chronic dialysis who is doing reasonably well is not an easy one. He frequently complains of fatigue, lack of energy, shortness of breath on exertion and depression, resulting from causes discussed here. His dependence upon the dialysis machine is not infrequently the cause of frustration.

COMMUNITY ORGANIZATION

V. *Question:* Please mark true or false.

[ ] A patient who needs chronic hemodialysis in Iowa must travel to Iowa City for dialysis treatment.

V. *Answer:*

[F] **There are two major nephrology centers in Iowa. In Iowa City a four-bed unit is in operation at the University Hospital and a 10-bed unit at the Veterans Hospital. In Des Moines an eight-bed unit is in operation at the Iowa Lutheran Hospital under the direction of Dr. Catherine Condon. Satellite dialysis units (operated in cooperation with the Iowa City center) are located in Ames (Dr. Kennedy Fawcett), Davenport (Dr. Edwin Motto), Fort Dodge (Dr. William Robb), Mount Pleasant (Dr. Harold Rankin), Sioux City (Dr. George Spellman), and Waterloo (Dr. J. Richard Long). Presently about 70 Iowans are undergoing chronic center dialysis.**

TABLE I

COMPARISON OF FIRST AND SUCCEEDING YEAR COSTS FOR HOME DIALYSIS*

	First Year	Succeeding Years
Training (including hospitalization)	$4,000-$5,000	
Equipment	7,200	
Dialyzer	800	
Dialysis machine	3,765	
Blood pump	565	
Monitor	382	
Heparin pump	250	
Water processor	1,245	
Other equipment and expenses	193	
Supplies	$2,000-$2,500	$2,000-$2,500

* A number of people who would be ideal home dialysis candidates are eliminated by lack of funds. It would be fair to say that many hospital insurance policies a few years ago did not cover dialysis. Recently, more policies have included dialysis expenses in the center and fewer yet in the home.

VI. *Question:* Please mark true or false.

[ ] Home dialysis can be accomplished in the home independent of any center dialysis program.

VI. *Answer:*

[F] **Home dialysis patients must be taught at and constantly supervised by a center unit and supported during times of illness. There are presently 30 home dialysis patients in Iowa scattered widely throughout the state under the supervision of the Iowa City center. These patients include those who appear better able intellectually and mechanically to care for themselves whether they are transplant candidates or not. There are also an undetermined number on home dialysis under the supervision of centers in bordering states. Though home dialysis takes more time in preparation, dialyzing and cleaning equipment, it does offer a greater degree of freedom and flexibility of dialysis hours for the patient and saves hours in traveling to and from a center.**

COST FACTORS

VII. *Question:*

Which of the following is correct? Center dialysis costs per year per patient:

[ ] $2,000 [ ] $25,000 [ ] $10,000

VII. *Answer:*

[X] **$25,000. The expense of center dialysis emanates from requirements for machine, sup-**

plies, water processing systems, and most important, nursing and technician personnel. This figure is fairly standard throughout the country and amounts to about $200 per dialysis and $20,000 to $35,000 per year depending upon the frequency of dialysis required.

VIII. *Question:*

1) Home dialysis costs per patient the first year are:
[ ] $5,000 [ ] $15,000 [ ] $25,000

2) After the first year it costs per patient:
[ ] $5,000 [ ] $15,000 [ ] $25,000

VIII. *Answers:*

[X] $15,000 first year, [X] $5,000 subsequent year. The initial expense of the equipment and hospitalization for training, which takes approximately 6-8 weeks, are the largest expenses of the first year but are not recurring expenses. Dialysis in the home during succeeding years is cheaper as outlined in the comparative figures in Table 1 (see Page 63).

Acute Renal Failure: Success and Failure of Treatment

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Des Moines

THE PATIENT with acute renal failure (ARF) is in a unique but dangerous position. He represents a medical emergency having no better than about a 60% chance of survival even in 1973. Yet if he does survive and if he avoids complications, he has an excellent chance of returning to near normal kidney function. It is the underlying disease process itself or nonrenal complications that produce morbidity and mortality.

In days of even recent past, physicians pessimistically accepted certain death in patients with acute renal failure even in the very young; loss of renal function led only to "iatrogenic drowning and ionic poisoning." But in recent years, especially since the advent of treatment with dialysis (both peritoneal and hemo), mortality has declined from near 100% to its present 40%. Treatment with the artificial kidney machine has contributed markedly to the successful treatment of acute renal failure but so has understanding and proper medical management of metabolic derangements.

Acute parenchymal renal failure is defined as a sudden progressive rise in blood urea nitrogen (and of course other chemicals handled primarily by the kidney) in the absence of glomerulonephritis, volume depletion and genitourinary tract obstruction, occurring during an acute illness in a patient with previously clinically normal renal function. (Using this definition eliminates pre- and post-renal azotemia). Oliguria (less than 400 cc/day) is usually but not always present. Table I summarizes the causes of ARF, combined under general headings.

TABLE I
CAUSES OF ARF

1. Ischemia
2. Septic Shock
3. Pigment
a. Hemoglobin
b. Myoglobin
4. Nephrotoxins
Antiobiotics, mercury and other heavy materials

REVERSIBLE CAUSES

Reversible causes of oliguria and azotemia must be identified and excluded during the initial examination of the patient with suspected

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ARF. The diagnosis of irreversible ARF can be made only after these reversible causes have been ruled out. Table II lists reversible conditions that may mimic ARF. The most important consideration in the differential diagnosis of almost all cases is the circumstances in which the renal failure occurred, directing the way various diagnostic procedures are utilized. In fact, careful consideration of the preceding circumstances may eliminate the need for many diagnostic procedures when the history clearly points to a specific diagnosis, e.g., ARF following a severe injury and massive destruction of muscle mass.

The initial assessment of the patient with oliguria and azotemia must include at least 1) determination of blood pressure and pulse both in the supine and the upright position (hypotension); 2) assessment of the state of hydration (hypovolemia); 3) examination of evidence of CHF, including measurement of CVP and (if possible) A-V oxygen difference; 4) evaluation of possible occult blood loss, including closed space hemorrhage as with fractures. Bilateral renal arterial or venous obstruction or urinary tract obstruction will not be ruled out by these maneuvers, the former occurring only rarely. But urinary tract obstruction must be suspected in any patient except in one with clinical findings clearly indicating an alternative diagnosis. A *unilateral* retrograde pyelogram will be necessary in suspected cases to exclude urinary tract obstruction; one needs only to be certain that *one* ureter is open to exclude obstruction as the cause for oliguria and azotemia.

There will be cases in which it remains difficult to differentiate between "non renal" oliguria and that due to parenchymatous kidney disease. Use of the glomerular filtration rate is of little value in the oliguric patient, but tubular function tests can be helpful. Table III outlines some of these tubular tests and how they can be applied in the differential diagnosis. Because the patient with acute parenchymatous renal failure is unable to concentrate the urine, to handle tubular exchange of sodium, and secrete creatinine the abnormalities in tubular function listed in the Table become diagnostic of ARF. Unfortunately there can be certain exceptions that may alter the laboratory results obtained. For instance, a patient on a very restricted sodium diet prior to the appearance of oliguria has little sodium delivered to the loops of Henle for reabsorption; the interstitial sodium and osmolar concentration in the medullary tissue is decreased and the counter current mechanism is upset. The patient will then be unable to concentrate the urine but *not* because of abnormal tubular function as the low urine osmolality might indicate.

TABLE II

REVERSIBLE CONDITIONS WHICH MAY MIMIC ARF BY PRESENTING WITH AZOTEMIA AND OLIGURIA

1. Hypotension due to any cause
2. Hypovolemia:
   a. Salt and water depletion
   b. Water depletion alone
   c. Blood loss
3. Congestive heart failure
4. Bilateral renal arterial or venous obstruction
5. Urinary tract obstruction

HIGH RISK GROUPS

There are groups of patients that must be classified as high risk to develop ARF. Table

TABLE III

TESTS OF TUBULAR FUNCTION IN DIFFERENTIAL DIAGNOSIS OF OLIGURIA AND AZOTEMIA

	Urine Na^+ mEq/L	Urine specific gravity	U_{osm}/P_{osm}*	U_{cr}/P_{cr}†
Pre-renal	<15	>1.020	>1.5	>20-50
ARF (ATN)	>30-40	<1.018	<1.2	<15-20
Obstructive uropathy	Variable (Low in short term)	—	—	Variable (Often high in short term)

* $\frac{\text{urine osmolality}}{\text{plasma osmolality}}$ † $\frac{\text{urine creatinine concentration}}{\text{plasma creatinine concentration}}$

TABLE IV

HIGH RISK GROUPS
(Patients prone to develop ARF)

1. Post Major Surgery
2. Obstetrical Accidents
3. Traumatic Injury
4. Severe Body Burns
5. Nephrotoxins

IV lists broad categories of patients at risk. Prevention of ARF entails maintaining a normal blood pressure, use of careful blood bank procedures to avoid transfusion reactions, employing potentially nephrotoxic drugs only when necessary and in appropriate dosage. It is important to carefully observe hourly urine outputs especially among high risk patients, and when oliguria is first detected stimulation with mannitol and intravenous diuretics should be started. A high index of suspicion is so necessary when dealing with the high risk patient; in other words keeping a wary eye out for any indication that renal insufficiency is developing may save a patient full blown ARF. There are those who believe there is a reversible phase in every situation before ARF finally develops.

PRACTICAL PATIENT SUMMARY

At the Iowa Lutheran Hospital (Des Moines) dialysis unit 20 patients with acute renal failure have been treated with hemodialysis in the past 18 months, this excludes 11 others who have undergone acute hemodialysis treatment for suicidal overdose of drugs. Table V summarizes these 20 patients. The mortality rate among the group was 50%, reflecting the rather advanced age of most of the patients at the time of treatment. All of those who died succumbed to their underlying disease, to overwhelming sepsis or to cardiac failure which had been present prior to ARF. Table VI lists the common complications found in a larger series of patients with acute renal failure; it will be noted most of the complications are infectious in nature.

TABLE V

SUMMARY OF PATIENTS WITH ARF (20)

Male 10		Female 10
Average age 57		
Recovered 10 (50%)	Average age = 54	
Died 10 (50%)	Average age = 60	

CAUSE OF ARF

	No.	Died
Ischemia	10	5
Septic shock	7	5
Pigment	2	0
Nephrotoxin	1	0

REASON FOR DEATH

	No.
Underlying disease	7
Cardiac arrest	2
Cardiac and respiratory failure	1

TABLE VI

INCIDENCE OF COMMON COMPLICATIONS OBSERVED DURING TREATMENT OF 110 PATIENTS WITH ARF

Septicemia
Genitourinary tract infection
Pneumonia
Cardiac arrhythmias
Acute pancreatitis
Acute parotitis
Respiratory tract obstruction
Wound infection
Gastrointestinal tract bleeding
Peritonitis
Pelvic infections
Acute cholecystitis
Myocardial infarction
Anesthetic death
Evisceration of wound

PRINCIPLES OF TREATMENT

Fluid Balance

Careful attention to fluid balance is critical to management of the ARF patient. Forced hydration must be stopped if pulmonary edema or water intoxication is to be avoided. A simple rule of thumb for calculating allowable fluid intake is:

Daily fluid intake = 5 cc/kg body weight + measured fluid loss

The best way to monitor and adjust fluid intake is by observing daily body weight—if a reliable scale is available! While in the oliguric phase of acute renal failure the patient should not gain weight from one day to the next and in fact should lose ½ pound per day if being managed conservatively. As will be mentioned later, if hemodialysis is available for treatment

more liberal use of fluid can be allowed.

In most patients with ARF diuresis begins within 14 to 21 days of the onset of oliguria. When diuresis begins, water, sodium and potassium balance must be constantly evaluated and adjusted upward to keep pace with urinary salt and water loss. Failure to match intake with output during the diuretic phase can and will result in dehydration and decreased renal perfusion with *re-emergence* of renal failure.

Potassium

The major route of excretion for potassium is the kidney and so people with ARF are at high risk to develop hyperkalemia. Acidosis, extensive tissue trauma, hyponatremia and any exogenous source of potassium are all factors contributing to high serum potassium levels. A good many patients with ARF undergo fatal derangements of potassium balance as a result of *exogenous* administration of potassium and thus represent preventable catastrophes. Most everyone recognizes that citrus fruits are high in potassium, but it is not as readily recognized that salt substitute, old bank blood and medications like penicillin—K+ all can be sources of considerable exogenous potassium; not to mention the potassium content of many of the too popular combination IV solutions.

Hyperkalemia must be recognized for the medical emergency that it is. Depending on the severity of the hyperkalemia, various methods are available for reducing the level of serum K+.

1) Immediate and short-lived
   - Calcium gluconate 10% 10-100 cc IV
   - Sodium bicarb 50-100 mEq IV
2) Moderately rapid and of moderate duration
   - Glucose and regular insulin (4 g/unit)
3) Slower acting
   - Exchange resins (Kayexalate) 15 gm q. 8 hrs (3 mEq of K+ are exchanged per gram)
   - Nasogastric suction
   - Restriction of potassium intake
4) Dialysis

Azotemia

The BUN rises as glomerular filtration decreases. The rate of rise of BUN depends on several factors including tissue catabolism, protein intake, administration of corticosteroids, dehydration, infections, gastrointestinal bleeding, the administration of catabolic drugs such as the tetracyclines and so forth. The rate of BUN rise varies from 10-50 mg % per 24 hours, the smaller figure by far the more preferable. By providing adequate calories in the form of carbohydrate (at least 100 gms per day) a "protein-sparing" effect is attained. If conservative treatment or peritoneal dialysis is the only means of treatment of a particular ARF case, then protein must be restricted as much as possible or eliminated from the diet. When hemodialysis is available, protein (as well as fluid) intake can be liberalized in an effort to restore positive nitrogen balance. A protein intake of about 1.0 gm per kg of body weight is beneficial while a fluid intake of 1000 cc or more over output is possible if hemodialysis is utilized regularly.

Acid-Base Balance

With the accumulation of break-down products of metabolism, acidosis develops. If the ARF is associated with severe shock, lactic acidosis may also develop. Correction of the acidosis becomes necessary when the serum bicarbonate level falls below 15 mEq/liter. Correction of the acidosis with sodium bicarbonate IV is possible, all the while keeping in mind the amount of sodium that is also delivered as an "accompaniment" of the bicarbonate.

If the patient is treated with hemodialysis, correction of the acidosis is quite easy and severe drops in pH do not occur.

Miscellaneous

All drug administration should be kept to a minimum, particularly the drugs handled primarily by the kidney. Digitalis drugs are frequently management problems and should be used sparingly if possible. Reduction of serum K+ levels by hemodialysis or peritoneal dialysis can unmask digitalis toxicity rather quickly.

Awareness of the high susceptibility of patients with ARF to infections of all types keeps the physician on his or her toes, and taking advantage of the help of the bacteriology department is necessary. To treat an infection one should use a non-nephrotoxic antibiotic if possible or use an antibiotic with known nephrotoxic properties in an intelligent fashion based on what is known about its handling by the diseased kidney.

INDICATIONS FOR DIALYSIS

If hemodialysis is necessary, it should be used early in ARF. As already mentioned, better dietary and fluid intake can be allowed during the oliguric phase, thus providing better nutrition and less of the consequences of severe malnutrition. Uremia is prevented with all of its disturbing symptoms including intractable nausea, convulsions and lethargy. Hyperkalemia—especially that caused by unpreventable massive tissue breakdown such as occurs in the crush syndrome—is more easily controlled when large amounts of potassium are removed from the body through dialysis.

Sometimes even in spite of diligent efforts, too much of a useful drug can accumulate in the body during ARF and dialysis may be helpful in removing the excess.

Finally, fluid overload can be more easily handled by hemodialysis than by more conservative measures. Often times, attempts to stimulate urine output initially will lead to fluid overload problems unwittingly and dialysis can be effectively used to re-establish the status quo.

SUMMARY

ARF is (usually) a reversible disorder of renal function from which the patient has a better than 50-50 chance of recovery, especially if he survives the initial cause and if complications are successfully combated. A variety of potentially fatal metabolic derangements occur in ARF that can be controlled by adequate medical management assisted by adequate hemodialysis. Extrarenal complications, particularly infections, must be carefully watched for and vigorously treated if the morbidity and mortality are to be reduced further.

Kidney Transplantation in Iowa

WILLIAM W. BONNEY, M.D.
Iowa City

THE IOWA TRANSPLANT SERVICE*† began patient care with its first kidney transplant in November 1969. In three years it performed 62 transplants in 60 patients. There are 40 more Iowa dialysis patients on the transplant waiting list, meaning that 100 suitable candidates have been evaluated in the various Iowa dialysis centers to date. Most of these patients depend upon unrelated (i.e., cadaver) kidney donors.

RESULTS

A certain success rate has been demonstrated in this patient series (Table I). Success is survival and function of the transplanted kidney, implying the correction of uremic complications and the potential for normal daily life. In some unsuccessful cases the patient was safely returned to dialysis, while other patients died. Table I is a summary of all cases to date, 1-38 months posttransplantation. These figures may be representative of long term success, since 73% of all failures have occurred within the first three months following surgery. (Roughly similar figures have been noted in a selective review of our first 33 patients, all one year or more following surgery). This success rate is comparable to that noted in the Ninth Report of the Human Renal Transplant Registry[1] and also the Tenth Report.

Dr. Bonney is an assistant professor of urology at The University of Iowa College of Medicine. He is chief of urology at the Iowa City Veterans Administration Hospital and coordinator of the Kidney Transplant Team. He is also chairman, Medical Advisory Board, Kidney Foundation of Iowa.

* The Iowa Transplant Service is a combined University Hospital and Veterans Hospital program under the general direction of the Transplantation Committee: John Thompson, M.D., co-chairman, Dept. of Medicine; Rubin Flocks, M.D., chairman, Dept. of Urology; Sidney Ziffren, M.D., chairman, Dept. of Surgery; John Colloton, Director, University Hospital, and Richard Eckhardt, M.D., Chief of Staff, Veterans Hospital.

† Transplant patient care is rendered by members of the Kidney Transplant Team: William Bonney, M.D., (Urology), Gerald DiBona, M.D., (Medicine), Annette Fitz, M.D., (Medicine), Richard Freeman, M.D., (Medicine), Charles Hawtrey, M.D., (Urology), George Kaloyanides, M.D., (Medicine), Richard Lawton, M.D., (General Surgery), Kenneth Printen, M.D., (General Surgery), Linda Rames, M.D., (Pediatrics), and Joseph Schmidt, M.D., (Urology).

TABLE I

TRANSPLANTATION RESULTS (IOWA TRANSPLANT SERVICE)

		Successful Transplant Function*	Transplant Removal and Dialysis	Death
Cadaver donor cases	45	22 (49%)	13 (29%)	10 (22%)
Live donor cases	17	15 (88%)	1 (6%)	1 (6%)
Total cases	62	37 (60%)	14 (22%)	11 (18%)

* Serum creatinine < 3 mg% in all cases and < 2 mg% in most, generally sufficient to reverse uremic complications and enable normal daily life.

From the viewpoint of individual patient risk, this represents a very significant morbidity. After considering all possible complications, most dialysis patients and their families are surprisingly eager to proceed with transplantation. A transplant does offer more potential for independence, full-time employment, and that certain measure of good health which can only come with normal renal function. In addition, reports from several centers have shown 5 year chronic dialysis survival rates no better than the *cadaver* transplant success rate demonstrated here.

TOTAL REHABILITATION

In a number of cases final recovery has been compromised by persistent or new complications. For example, hypertension has sometimes continued despite removal of the diseased kidneys, and the necessary medication can cause disabling symptoms. Yet, on the whole, patients with a successful transplant have enjoyed a return to near-normal health. Muscle mass has been restored, peripheral neuropathy has healed, and completely unrestricted physical activity has become once more possible.

TABLE II

CAUSES FOR TRANSPLANT REMOVAL

	Live Donor Cases	Cadaver Donor Cases
1. Rejection because medication was stopped		5*
2. Wound infection or urinary fistula		2
3. Hyperacute rejection in the operating room		1†
4. Chronic rejection	1	1
5. Acute tubular necrosis		4

* One case gastro-intestinal bleeding, remainder infection.
† Very high requirement for repeated transfusion on dialysis at a collaborating hospital.

Therefore, one might expect nearly all successful transplant patients to enjoy total rehabilitation, a resumption of normal full time activity and responsibility. In fact, this final step has been achieved in less than ¾ of our successful cases. Reasons for the limited achievement have included a) inadequate job skills or educational preparation, b) altered daily habit patterns during the prolonged illness, c) public misunderstanding about the degree of health possible, and d) minor residual incapacities such as peripheral neuropathy.

MAJOR UNSOLVED PROBLEMS

The major challenges or needs are best illustrated by our treatment failures. Failure to achieve a successful transplant has two end results: Mounting complications may cause the patient's death, often at a time when the transplant is not functioning well. In other cases it is possible to stop medication, return to dialysis, and remove the kidney in preparation for another donor. For each type of situation in our experience, the causes are listed in Tables II and III.

The most pressing problem, in our center

TABLE III

CAUSES OF DEATH

	Live Donor Cases	Cadaver Donor Cases
1. Pneumonia		5
2. Gastric perforation with subsequent pneumonia		1
3. Technical or surgical complication		2
4. Accidental death		1
5. Immediate post-operative aspiration pneumonitis		1
6. Spontaneous intracranial hemorrhage	1	

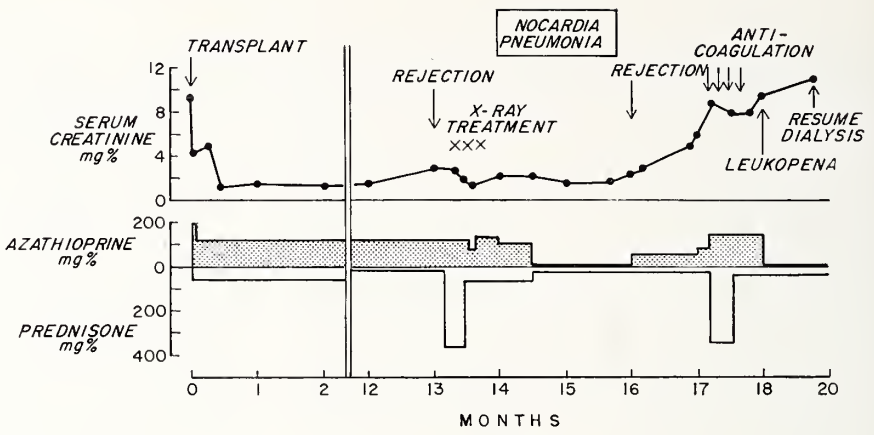


Figure 1. Rejection after infection prevented use of immunosuppressive drugs. This 28-year-old patient received a cadaver-donor transplant in January 1971. During the 13th postoperative month there appeared the first sign of rejection episode, readily reversed. However, soon after that a Nocardia pneumonia prompted the withdrawal of immunosuppressive drugs. Although the patient recovered from infection on sulfadiazine and other agents, there soon followed a chronic rejection not controllable by available treatment.

and others, continues to be immunosuppression. For many cadaver-donor patients the rejection tendency is too strong and cannot be controlled with safe doses of the medications in current use. Attempts to salvage the kidney are often associated with infection or other complications (see Figure 1). For many years small animal research has suggested that anti-lymphocyte serum would provide a powerful adjunctive treatment. This author has raised large quantities of antiserum for both human and experimental use. Its immunosuppressive potency has proved to be variable and impossible to assay, so that its use in patients could not be justified. Other centers have performed large scale clinical trials using similar material, with mixed results at best. Our interest has, therefore, turned to the laboratory assay of drug combinations not currently in use. In a cooperative clinical study we are also closely evaluating Azathioprine potency in relation to leukopenia, its most immediate toxic side effect.

Another approach to the rejection problem is precise donor-recipient matching by histocompatibility typing, a discipline still in a developmental stage. Under the direction of Dr. John Thompson the Iowa Tissue Typing Laboratory has been able to predict accurately long term success whenever an immediate family was under consideration. Here and at other centers, however, the true match between unrelated individuals has been much harder to predict. We are, therefore, selecting recipients for each cadaver donor on the basis of a new genetic matching scheme proposed by Dr. Thompson.

When a transplant has failed it is possible to perform a second one with ultimate success (Figure 2). After removal of the first kidney

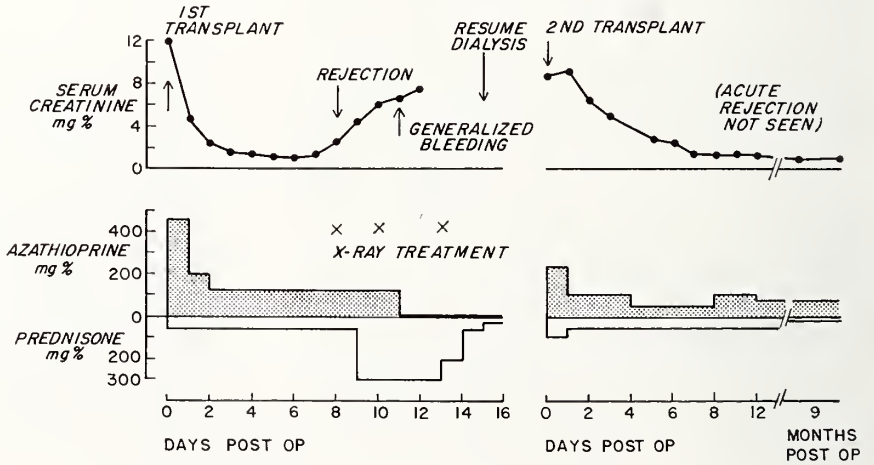


Figure 2. Successful "second" transplant. A 26-year-old woman with glomerulonephritis. Cadaver-donor transplant September 1971, lost from acute rejection because a generalized hemorrhagic tendency made it necessary to stop medication. December 1971 second cadaver donor transplant with continued good function, no sign of any rejection tendency.

the recipient often carries serum antibody against antigens from that donor. This antibody, together with usual tissue typing, helps to pick another donor with an entirely new set of antigens. Therefore "first" and "second" transplants have an equally good prognosis. This case illustrates the close relationship between dialysis and transplantation. The two disciplines function as one team while patients move back and forth from one treatment modality to the other.

Another challenging problem is to maintain cadaver organ viability (see Dr. Lawton's article in this symposium). As the program depends more upon recovery teams in other communities, it becomes logistically more difficult to preserve kidney function through the donor's hospital management, organ recovery, transportation, overnight profusion and transplantation.

COST

An itemized accounting of typical donor's and recipient's cost has been previously presented.[2] Although service to the patient has been increased, still the overall cost of transplantation and one year's management compares favorably with the first year of home dialysis (see article by Drs. Richards and Freeman in this symposium).

REFERRAL FOR EVALUATION

Any patient under consideration should be referred to an established nephrology-dialysis center in the state. Criteria for dialysis often include suitability for transplantation, and the two types of workup can be carried out simultaneously.

PHYSICIAN PARTICIPATION

A growing number of Iowa physicians have agreed to help in the postoperative management of transplant patients across the state. Although contact and regular visits are maintained with the Transplant Service, responsibility for continued success rests once again with the family physician. It is a source of great satisfaction to see chronically ill patients finally return to full community life.

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2. Bonney, W. W.: Kidney transplantation in Iowa: progress report. J. Iowa Med. Soc., **60**:247-254, 1970.

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Organ Procurement and Preservation

RICHARD L. LAWTON, M.D.
Iowa City

FEWER THAN ONE-THIRD of dialysis patients have a suitable living related donor, therefore a transplant program depends on the recovery and use of cadaver organs. The American public has accepted the complete treatment of end stage kidney disease. The Kidney Foundation of Iowa through its chapters has been distributing donor cards in the state. The Foundation "Gift of Life" program is aimed at increasing public cooperation.

Iowa physicians play a key role in donor identification and organ recovery. The professional community has responded and organ recovery activity has begun in Cedar Rapids, Davenport, Waterloo, Des Moines, Sioux City and Fort Dodge.

A satisfactory cadaver donor may have the following characteristics:

1) Under the age of 50 years

2) Severe head injury or cerebrovascular accident, with medical examiner's release where appropriate

3) No history of cancer, diabetes, kidney disease, chronic hypertension or infection

4) Normal creatinine clearance during the hours just before organ recovery

5) Complete dependence on artificial ventilation

6) Deep coma with no spontaneous movement, fixed-dilated pupils and other signs of mid-brain death

7) Family willing to donate

The care of a potential donor is extremely important. He or she is usually in the environment of an intensive care unit, and it is mandatory that cardiovascular status remain stable (adequate use of colloid and electrolytes) in order to insure a voluminous urinary output. Simple laboratory measurements of kidney function are invaluable and should include routine urinalysis and serum creatinine.

Once a potential donor has been identified by his physician, it is seldom a problem to get permission for donation. In some instances the family has taken the initiative and asked the physician whether the organs might be used to help somebody who needs a transplant. Increasingly, persons feel it is their moral responsibility to prevent the useless waste of vital organs. In the State of Iowa at the present time, there are approximately 50 dialysis patients who do not have a suitable living donor and are dependent on cadaver donation.

Brain death is accepted by the medical community as an ethical and moral termination of existence. The diagnosis of brain death is not new, but in the context of organ recovery, it has been more carefully defined. Any licensed physician can make the diagnosis without the use of special instrumentation (EEG). Basically, brain death means the death of the cerebral cortex and the mid-brain. This state is irreversible and will soon lead to cardiorespiratory collapse if unusual measures are not taken. After the primary physician has established the time of brain death, the cadaver is taken to the operating room where organ recovery is begun. With respirator control and usual aseptic technique, a laparotomy is performed. The kidneys are removed and the renal arteries are immediately flushed with a solution of Ringer's lactate or Collins' solution at 4°C (Figure 1). Following this "core" cooling, the organs can be packaged and stored in an insulated container with ice (Figure 2). This type of cold storage can be used for a number of hours; long enough to permit transportation to the Transplant Center in Iowa City. The organ will then be placed on dynamic perfusion, which includes a pulsatile pump, heat exchanger, oxygenator and specially prepared plasma. It can be kept in dynamic stor-

Dr. Lawton is a professor in the Department of Surgery at The University of Iowa College of Medicine. He is in charge of the Organ Procurement Section of the Kidney Transplant Team. He is now president of the Kidney Foundation of Iowa.



Figure 1. Organ recovery. Iowa Transplant Service surgeons (Drs. Charles Hawtrey and Richard Lawton) prepare a newly removed kidney for preservation. New techniques and equipment are extending the preservation.

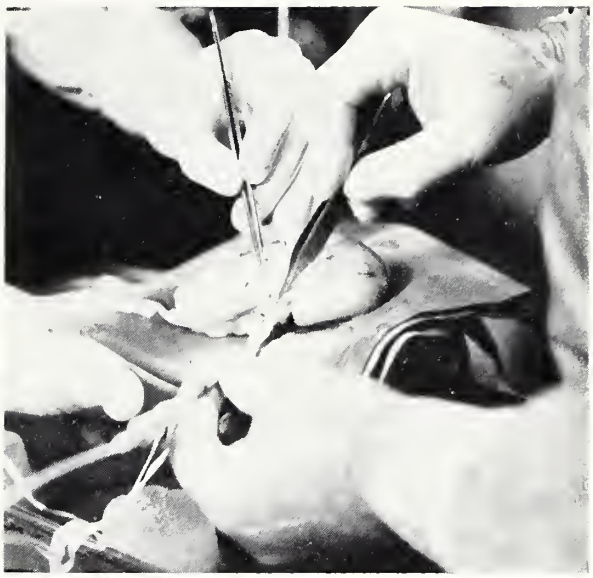


Figure 2. Cold washout of a donor kidney. Immediately after removal the renal circulation is washed out with chilled electrolyte solution. With simple iced packing it will then remain viable for eight hours of transportation and storage.

age for over 24 hours, sufficient time to allow the Typing Unit to match the cadaver kidney with a recipient and prepare him for transplant.

Organs have been recovered in several Iowa communities with the help of physicians and hospital personnel. In at least some of these strategic areas there will eventually be professional teams that can recover organs independently and ship them to Iowa City for transplant. Physicians have been very cooperative in trying to make the Transplant Service a success.

Some activities of the Organ Procurement and Preservation Unit are supported by the Regional Medical Program, which includes the training of an Extra-Corporeal Technologist (Preservation). The Departments of Surgery, Urology, and Hospital Administration of the University of Iowa have funded a portion of the project. We have had excellent cooperation from the Governor's office as well as the Highway Patrol and National Guard. A member of the Recovery Team can be reached at all times through the University switchboard, (319) 356-1616. Ask for the *Transplant Beeper.*

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Feb. 5-8	Training for Physicians in Coronary Care Unit Techniques
Feb. 7	Ophthalmology Clinical Conference
Feb. 13-16	Refresher Course for Family Physician
March 4-7	Intensive Course in Pediatric Nutrition
March 7	Ophthalmology Clinical Conference
April 4	Ophthalmology Clinical Conference
April 9-12	Training for Physicians in Coronary-Care-Unit Techniques
April 19-21	In-House Conference for Practitioners

Unless otherwise specified all courses and conferences are held at The U. of I. College of Medicine, Iowa City.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

OUR SCIENTIFIC SECTION

A somewhat unique educational service is performed by the JOURNAL this month. Readers of the scientific section will recognize quickly the entire discussion concerns the treatment of renal disease. Particular attention is directed to renal treatment developments which have occurred in Iowa. One of the articles (by Richards and Freeman) even offers the reader the opportunity to match wits with the authors.

Here's the unique aspect of this venture: The material offered in the JOURNAL serves as a prologue to a series of physician education conferences to be held around the state soon on this important subject. The series schedule is found on Page 56.

The JOURNAL is pleased to have been part of this worthy continuing education effort. We commend Dr. Bonney and the others involved for their extensive and conscientious efforts. We encourage your participation in these regional meetings.—M.E.A.

ADOLESCENT PROFILE

The November 1972 Information Bulletin of the U. S. Maternal and Child Health Service reports on a study by Minnesota Systems Research, Inc. on the provision of health care services to adolescents in the 1970's. The study was federally funded, but the conclusions do not necessarily reflect the views of the research institution nor MCHS. Samplings from the report are interesting and in some instances disturbing.

According to the report, the adolescent is having to make a great deal of effort to solve his identity problem, and in doing so he examines his parents with a critical attitude. He also tends to rely on his peers for a sense of belonging. The report goes on to conclude that more study is necessary in parent-adolescent relationships. So what else is new?

It seems adolescents lack emotional security and find life monotonous because of adult attitudes and values, commercial manipulations, and hypocrises of life. Consequently, a youth culture develops, drugs are taken, and sexual activity rises with its consequences of epidemic proportion of venereal disease, and increasing numbers of adolescent pregnancies. It would seem that the younger generation feels the world is doomed, and that freedoms must be exploited to the fullest—freedom of drug use, freedom of cultural changes away from taboos and mores of the past, freedom of sexual activity outside the state of matrimony, and freedom of criticism that is not always constructive. Freedom has an inherent responsibility—a *responsible* choice of right or wrong.

Perhaps some adult actions are wrong and not representative of a responsible choice. Life is a two-way street, and the traffic in the other direction has a right to its share of the road. Wouldn't it be great if we could communicate with the adolescent in such a way that everyone would be happy? It is possible. These young citizens will listen to adults who show interest in them. It is time that responsible

adults show such an interest, so the adolescent does not have the necessity or inclination to listen only to adults who tend to be irresponsible—irresponsible to society as well as themselves. We hear so often that the adolescent derives his non-judgmental attitudes from the professional workers with whom he associates. So, should we stand by letting venereal disease rates climb, moral attitudes deteriorate, and concern for good health fall by the wayside because of a feeling we should neither judge nor lay down certain regulations for responsible living? Has our life deteriorated to a state of complete disregard for society as a whole? Does the individual no longer have any degree of respect for himself?—M.E.A.

HIGH HONOR FOR DES MOINES PHYSICIAN

A high honor was bestowed upon a Des Moines surgeon December 6 in London, England. Julian M. Bruner, M.D., a specialist in hand surgery, presented the Sixth McIndoe Lecture, honoring the late Sir Archibald McIndoe, before the British Association of Plastic Surgeons at the Royal College of Medicine.

Dr. Bruner is the first American to be so honored by that association. His paper was entitled, "The Contributions of Sir Archibald McIndoe to Surgery of the Hand."

McIndoe gained his stature in surgery during World War II for his brilliant care of injured Royal Air Force pilots. The care provided was not only surgical for Sir Archibald also provided assistance to those men in the areas of rehabilitation and job placement. These patients organized the exclusive Guinea Pig Club with an insignia consisting of a guinea pig with wings. Approximately 450 members remain in this unique club.

In addition to the honor of the lecture presentation, Dr. Bruner was given a silver medallion by members of the Guinea Pig Club, a medallion personally inscribed to him. It is obvious from speaking to Dr. Bruner that he takes great pride in his past association with McIndoe during their surgical training at the Mayo Clinic.

The physicians of Iowa also salute our learned and accomplished colleague.—M.E.A.

WILLIS M. FOWLER: AN APPRECIATION

Willis Marion Fowler was born in New York, 11 August 1900, and died in Iowa City on 9 September 1972. He had his undergraduate training at Grinnell College and received his M.D. degree at the University of Iowa in 1926. An internship at the Cleveland City Hospital and a senior internship at the Henry Ford Hospital followed. He then returned to his alma mater where he was successively resident, assistant professor, associate professor, and finally, for the last 24 years of his life, a professor in the Department of Internal Medicine. For two years, 1946-1948, he was acting head of the department. Dr. Fowler, at various stages of his career, became a member of Sigma Xi; Alpha Omega Alpha; president, Johnson County Medical Society; member, American Society for Clinical Investigation; Central Society for Clinical Research (president in 1945); Central Interurban Clinical Club (secretary in 1945); and the Central Clinical Research Club (president from 1944 to 1946). He was an organizer and president in 1944 of the Central Hematological Club; secretary, Iowa Clinical Medical Society; fellow, American College of Physicians (he served as Iowa governor for many years); and a member of the Association of American Physicians; the Society of Hematology; and the American Heart Association; and a number of others.

Dr. Fowler bore the brunt of teaching during the difficult years of World War II when he constituted a quarter of the staff of the department of medicine and probably carried half the teaching load. Despite this he was able

to serve for a long time as director of the clinical laboratory; to write a widely-praised book, HEMATOLOGY, which went through several editions; and chapters in a number of textbooks. During the hard days of World War II, it became evident that Dr. Fowler's wife was suffering from a brain tumor for which all manner of heroic and painful treatment did too little. He managed, nonetheless, to provide a fine home environment for his growing sons and cared most affectionately for his wife through all their vicissitudes.

Following the death of Fred M. Smith in 1946, the additional responsibilities of being acting head of the Department of Internal Medicine were thrust upon him during the turbulent transition into the early post-war era. For two years he did yeoman work, getting the department back on its normal footing. Somewhat later he was one of three faculty members who ran the medical school during an interregnum between deans.

Those who knew Bill Fowler only during the latter years of his life when he suffered from many of the handicaps and complications of hypertension, do not remember what a charming and delightful companion he was, quiet, without much small talk, but a good conversationalist in a small group.

I had a special fondness, as well as deep admiration, for Bill Fowler. When I succeeded him as head of the department he was in a position to influence affairs any way he chose. There was never anything small, petty, or mean about Bill Fowler. He pitched in and supported the new program with loyal devotion to the department, the university, and the medical community. His effort was wholehearted and his enthusiasm was genuine at a time when he must have felt that he had been bypassed. He might have been embittered—not Bill Fowler.

Solid, dependable, well-trained, a devoted colleague, an industrious worker, a kind hard-working physician, he had those abiding traits of character and excellence upon which the right function of the true physician stands. I rank Bill Fowler high on the list of friends who have been fellow toilers in the vineyard of medicine—a truly fine gentleman.—WILLIAM B. BEAN, M.D., *Sir William Osler Professor of Medicine.*

IOWA MEDICAL MISCELLANY *(Continued from page 45)*

LEGISLATIVE COMMITTEE . . . Further strategy for new session of the Iowa General Assembly was mapped January 17 by IMS Legislative Committee.

SPECIALTY GROUPS . . . Special conference for Iowa specialty group representatives occurred January 24 at Society Headquarters. Meeting is part of IMS effort to keep Iowa medical leaders abreast of developments.

MATERNAL & CHILD HEALTH . . . Consideration of pending measures to extend Medicaid early and periodic screening program to those between 7 and 21 occurred January 12 in Iowa City. Society's Committee on Maternal and Child Health met in conjunction with Medicaid conference.

LADIES' BRUNCH . . . Annual brunch for wives of Iowa's legislators was given January 17 by IMS Woman's Auxiliary. Mrs. Robert Ray headed list of guests.

PHARMACY MATTERS . . . IMS Interprofessional Committee conferred January 17 with representatives of Iowa Pharmaceutical Association.

TRANSFER OWNERSHIP . . . Ownership of Omaha's Creighton Memorial Saint Joseph Hospital has been transferred from Sisters of Saint Francis of Colorado Springs to Creighton Omaha Regional Health Care Corporation. Move is part of Corporation's development and operation of new medical center as an affiliate of Creighton University and its Division of Health Sciences.

APPOINTED . . . Dr. Terence H. Williams has been appointed to head the U. of I. Department of Anatomy. Now at Tulane University, Dr. Williams previously taught at Harvard and in England and Ireland.

FP EXAM . . . The American Board of Family Practice gives its next certification exam October 20-21. Application deadline is August 1.

IN THE PUBLIC INTEREST



REPORT IOWA PHYSICIAN ASSISTANT PROGRESS

IN RECENT WEEKS the press has reported the concern of some Iowans who believe the state has not moved with sufficient dispatch in the consideration and actual utilization of the physician's assistant (PA).

More recently, on January 31 to be exact, the State Board of Medical Examiners and the Governor's Advisory Committee on Physicians' Assistants submitted its report on this subject as required in legislation passed by the 1971 Iowa General Assembly.

One sentence from this new law (Chapter 137) is meaningful (1) as a prelude to the ensuing highlighting of the PA report and (2) as a factor in assessing how fast Iowa has moved and how fast it should move in utilizing this neophyte health worker. In speaking of approving education and training programs for the physician's assistant, the law declares:

"The Board shall adopt and publish standards to insure that such programs operate in a manner which does not endanger the health and welfare of patients who receive services within the scope of the program."

The passage about *endangering the health and welfare of patients* is significant. The intent of Iowa's lawmakers appears obvious. They're saying, in our interpretation, "Let's not jeopardize the quality of care which is available. Still, let's make premium use of our physician manpower by authorizing their use of personnel, where and when possible, to perform tasks for which they have been suitably trained."

DELIBERATE SPEED

Additionally, this statutory assignment could easily be interpreted as saying, "Let's be about this important task but let's do so with intelligence and deliberateness."

And it appears from a reading of the aforementioned report that such has been the case. In ably describing this new category of health manpower, the Board of Medical Examiners and the Advisory Committee declare: "The concept of a physician's assistant and the delegation of physician tasks is not new. Physicians have been delegating tasks of all kinds to medical office assistants and nurses for years. What is new is the desire to formalize training to enable a new category of personnel to perform services which extend the physician's capabilities in the diagnostic and therapeutic management of patients."

Herein lies the formidable challenge, to formalize the process by which the individual bearing this designation achieves the desired functioning status. In other words, how does one prepare for this humanity-serving job, e.g., by on-the-job training, by formal education, by military service, etc. And once prepared, how is this preparation measured and recognized.

These are the difficult issues which have

taken the time of the Advisory Committee and the Board of Medical Examiners over the past 15 months. They deserve serious contemplation in the interests of the citizens of Iowa.

In this period five applications have been made to the Board for legal standing as a physician's assistant. Four of these have been approved under provisions of the law. The fifth has been deferred pending equivalency testing.

TRAINING PROGRAM

Also, in the brief interval since passage of the physician's assistant legislation, The University of Iowa College of Medicine has enrolled (in September) its first class (10 students) in a Physician's Assistant Training Program. This two-year program has been developed to meet standards established by the American Medical Association and other accrediting groups. These students (another 14 are to be enrolled in June) are being prepared to assist primary physicians (those who have first contact with patients) because this is the area of greatest need in Iowa.

While educational programs surfacing about the country vary in length from several weeks to five years, depending on the education and experience required of candidates for admission, The U. of I. program is of two years' duration in the belief it will take this long to provide the course work and clinical experience necessary to equip the assistant for his tasks and to assure the employing physician, his patients and others that the PA possesses the necessary capabilities.

With the establishment of this pilot education program, Iowa is in the vanguard of states to make a sound, University-based effort to train the PA. Iowa has received preliminary approval from the AMA for its new training program. The Board of Medical Examiners has approved this program as it is empowered and required to do. And it has suggested this be the only such program in Iowa during this early period.

The clamor for official designation as a physician's assistant has not brought to the surface as many applicants as many may have expected. This is evidenced by the receipt of only five applications by the Board of Medical Examiners. Estimates nationally as to the number of graduates of physician's assistant programs range from 200 to 400. Aware of these factors, it is fair to conclude Iowa's progress has been satisfactory, and certainly not lagging.

ACCOMPLISHMENTS TO DATE

The Board and Advisory Committee have concluded they will consider only the development and utilization of the Class A physician's assistant, the individual best able to integrate and interpret medical findings on the basis of general medical knowledge and to exercise a degree of independent judgment. In keeping with this, the Board-Committee cites in the report the following accomplishments:

1) Approval of the training program at The U. of I. College of Medicine.

2) Establishment of general guidelines for review of requests from physicians for the utilization of assistants under the new Iowa law. The Board will grant certification to assistants from approved Class A training programs. It will call on the faculty of the Physician's Assistant Program at The U. of I. to assist in judging equivalent training obtained in an informal manner by applicants. It will grant temporary status at this time to acceptable applicants for certification and will require all those who desire permanent approval to successfully complete a national certifying examination (such an exam is scheduled to be ready in 1973).

3) Development of forms for use by physicians and assistants in applying for review and registration.

4) Maintained contact with the Iowa Medical Society, Iowa Society of Osteopathic Physicians and Surgeons, Iowa Nurses' Association and Iowa Hospital Association.

5) Reviewed the development of national certification examinations to serve as equivalency testing programs for those who have not completed formal PA training.

6) Assembled and analyzed extensive PA data.

In concluding the report, the Board of Medical Examiners and Advisory Committee accept the task of continuing this important work. That there is interest, ferment, expectation, etc., in this general area, is perhaps an understatement. And, too, there is honest concern over legal status, patient acceptance, co-worker relationships, etc. The Board of Medical Examiners and the Advisory Committee deserve plaudits, not criticism, for the effort expended to date.

Doctor's Business

by LARRY E. LEAVERTON

PERSONAL FINANCIAL AFFAIRS REQUIRE ATTENTION

There are many physicians whose offices are models of efficiency by most standards. However, in probing their personal affairs we often find neglect, disarray and lack of direction and planning. Should accident, sudden illness, or untimely death strike, the family of the disorganized physician is burdened with confusion and expense that could be minimized by advance planning.

Most doctors make retirement plans but how many actually retire? Of equal importance with retirement is an orderly plan for the handling of personal affairs in the event of death.

Estate problems can be eliminated or minimized by careful planning with an attorney, trust officer, insurance agent and other advisors.

Why is proper estate planning necessary?

1) To insure maximum and orderly accomplishment of objectives in the distribution of estate assets, and to assure maximum estate utility through provision for proper management.

2) To insure minimum tax erosion of the estate.

Many physicians are unaware of the size of their potential estates. For an attorney and trust officer to determine this they must have full knowledge of the complete financial picture. An up to date inventory of all assets and liabilities is necessary. Most physicians have such a record for their office practice but have little idea of cost, purchase dates, current value, etc., of such personal assets as their residence, securities, properties, or bank accounts. Or, they may know but no one else does in the event of their death. Also important are complete and current summaries of life insurance programs, tax files, deeds to properties and legal documents such as divorce decrees.

When determining the size of an estate it is important to use current asset values, and to include all life insurance except that owned by others. Don't count on a large amount from the sale of the medical practice, they are not readily salable with today's shortage of doctors. The major portion of the accounts receivable from patients should be collectible. If a partnership or group practice is involved the partnership agreement should specify exactly what the withdrawing partner's estate would receive in the event of his death.

Almost basic to the physician's personal financial plan is the will, however, it is frequently neglected. Problems arise from failure to make a will or to update an existing one. The will must be periodically examined by the attorney to keep it current as to desires, current family situation, and tax legislation. Opinions on bequests may change. It is important for the wife to have a current will coordinated with her husband's. Both should provide for a common disaster.

Matters such as how the doctor wishes to have his practice disposed of, the value of some of the assets, wishes on disposition of records, termination of office personnel, location of inventories and records, names of advisors and other instructions can be included in a testamentary letter. While not legally binding, it is helpful to heirs and the executor.

If you live to be 100, the planning you have done will not be entirely wasted. The efforts expended will give you peace of mind in the interval. An appraisal of your current financial position might reveal how little you have actually provided for protection for your family.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

DRUG LETTER *(Continued from page 53)*

Included in the group of nonnarcotic antitussives are *dextromethorphan* (Romilar), *levopropoxyphene* (Novrad), *noscapine* (Nectadon), *dimethoxanate* (Cothera), *pipazethate* (Theratuss), *chlophedianol* (U10), *carbetapentane* (Toclase), and *benzonatate* (Tessalon). *Dextromethorphan hydrobromide* is the dextro isomer of the methyl ester of levorphanol (Levo-Dromoran) and *levopropoxyphene napsylate* is the levo isomer of dextropropoxyphene (Darvon). *Noscapine* is a member of the benzylisoquinolone group of opium alkaloids. Two of the nonnarcotic antitussives, *dimethoxanate* and *pipazethate,* are phenothiazine derivatives. *Chlophedianol* is structurally similar to the antihistaminics. *Carbetapentane* is chemically and pharmacologically related to the atropine-like drug, caramiphen (Panparnit). *Benzonatate,* a congener of tetracaine, appears to have both a central and peripheral action.[3, 7]

The usual oral dosages of the nonnarcotic antitussive agents are listed in Table II.

PERIPHERALLY ACTING ANTITUSSIVE AGENTS

The peripherally acting antitussives may be grouped as: 1) demulcents, 2) agents which inhibit peripheral receptors, and 3) expectorants and mucolytics. Demulcents, such as glycerin, honey, acacia, and licorice by coating an irritated pharyngeal mucosa may have a brief antitussive effect if cough is secondary to such irritation. Many of the syrups and lozenges currently in use have a temporary demulcent effect. Local anesthetic agents which are useful in bronchoscopy and bronchography very effectively control cough during these procedures. *Benzonatate* (Tessalon) has been reported to act by inhibiting stretch receptors in addition to its central action.

The expectorants will be mentioned only briefly. Agents which act by increasing respiratory tract fluid might be expected to facilitate expectoration of secretions and thus have an antitussive effect. A number of these agents have been studied in various animal species. Among the agents found to increase the secretion of respiratory tract fluid in animals are ammonium chloride, ammonium carbonate, potassium citrate, potassium iodide, aminophylline, ipecauanha, glyceryl guaiacolate, volatile oils, terebene, terpin hydrate, tolu balsam, creosote, paregoric, chloroform, and various sapo-

TABLE 1—NARCOTIC ANTITUSSIVE AGENTS

Agent	Usual Adult Dosage	Usual Pediatric Dosage
Codeine	8 mg to 15 mg, three or four times daily	1 mg to 1.5 mg/kg/24 hr or 33 mg to 50 mg/M^2/24 hr divided into 6 doses
Hydrocodone	5 mg to 10 mg, three or four times daily	0.6 mg/kg/24 hr divided into three or four doses, or 20 mg/M^2/24 hr divided into three or four doses
Ethylmorphine	5 mg to 15 mg, three or four times daily	
Morphine	2 mg to 3 mg, three or four times daily	0.057 mg/kg, three or four times daily
Methadone	1.5 mg to 2 mg, every three to four hrs as necessary	0.18 mg/kg/24 hr divided into four to six doses or 5 mg/M^2/24 hr divided into four to six doses

TABLE 2—NONNARCOTIC ANTITUSSIVE AGENTS

Agent	Usual Adult Dosage	Usual Pediatric Dose
Benzonatate (Tessalon)	100 mg three to six times daily	50 mg three times daily
Carbetapentane (Toclase)	15 mg to 30 mg three or four times daily	Age 4-12: 7.25 mg three or four times daily Age 2-4: 3.6 mg three or four times daily
Chlophedianol (Ulo)	25 mg three or four times daily	Age 6-12: 12.5 to 25 mg three or four times daily Age 2-6: 12.5 mg three or four times daily
Dextromethorphan (Romilar)	15 mg to 30 mg one to four times daily	Over 4:7.5 mg to 15 mg one to four times daily 1-4: 3.75 mg to 7.5 mg one to four times daily
Dimethoxanate (Cothera)	25 mg to 50 mg three or four times daily	Over 8: same as adults 2-8: 12.5 mg to 25 mg three or four times daily
Levopropoxyphene (Novrad)	50 mg to 10 mg every four hours as required	0.5 mg/lb every four hours as required
Noscapine (Nectadon)	15 mg to 30 mg three or four times daily	
Pipazethate (Theratuss)	20 mg to 40 mg three or four times daily	If 23 to 46 kg (50-100 lb), 10 mg three or four times daily

Radiology Window

CASE NO. 10

This 39-year-old male Negro was admitted for study of his weight loss (35 pounds within three months) and his one plus albuminuria. He gave a negative past G.U. history and was seen in the radiology department for an IVP. The most probable diagnosis based upon this IVP film would be:

1) Crossed ectopia with fusion.
2) Crossed ectopia without fusion.
3) Nonfunctioning right kidney with a duplicated pelvis of the left kidney.
4) Very mobile right kidney near the midline.

Please turn to page 82 for the correct diagnosis and a further discussion of the case.

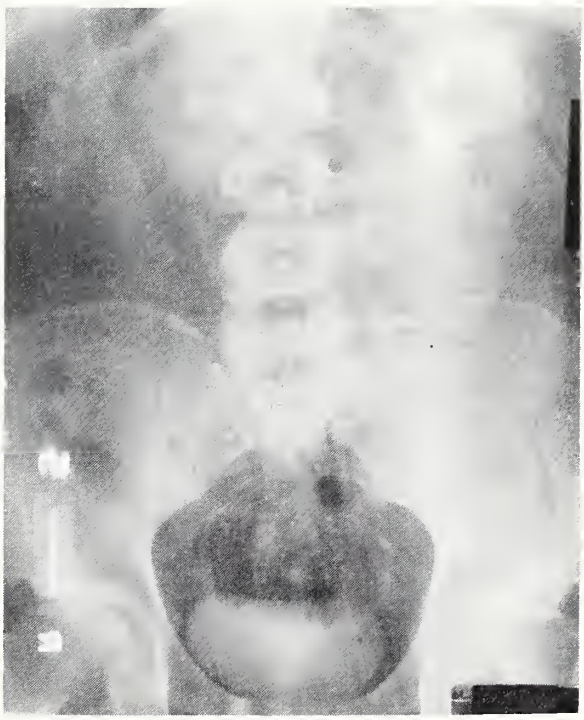


Figure 1

This radiologic feature has been prepared and provided by members of the Radiology Department at Mercy Hospital in Des Moines. The co-authors are N. W. Irving, M.D., R. E. Hines, M.D., B. B. Augspurger, M.D., K. Tigrani, M.D., J. Olivencia, M.D. and B. Houle, a medical student.

DRUG LETTER *(Continued from page 80)*

nins and glycosides.[4] A number of these agents are currently used in antitussive mixtures. In the animal studies the dosages required to increase respiratory tract fluid were, in general, higher than the therapeutic dosages used for man. Studies in man have generally shown no detectable decrease in sputum viscosity or increase in sputum volume with the expectorant agents, however, several of the agents found to be effective in animals are subjectively of benefit to man.[5] The efficacy of these agents alone as antitussives and the role of these agents in cough mixtures has not been fully defined. Objective clinical studies in patients with chronic cough are needed.

ANTITUSSIVE MIXTURES

In addition to the antitussive agents listed here, many antitussive mixtures are available. These mixtures may variably contain a demulcent, an antihistamine, a decongestant, an antipyretic, a bronchodilator, and an expectorant in addition to a narcotic or nonnarcotic agent. At present the efficacy of these mixtures should be judged mainly on the basis of the known antitussive agent they contain. Objective clinical studies in chronic cough comparing efficacy of the mixture with that of the antitussive agent alone are not available. No final judgment as to efficacy or relative potency can be made upon the data of subjective studies alone.

REFERENCES

The references noted in this article are available on request from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

RADIOLOGY WINDOW

(Continued from page 81)

CASE NO. 10

The correct answer is crossed ectopia with fusion (No. 1) and this was clearly demonstrated by retrograde studies.

DISCUSSION AND EMBRYOLOGY

Of the world's population 10% have G.U. anomalies and of these, 50% involve the upper urinary tract. Ectopia in this case is not a ptotic or abnormally mobile kidney, but instead it is due to the development of foci in unusual positions, generally low in level.

Embryologically, the adult kidney, the metanephros, develops after two primitive stages have regressed. The most primitive is the pronephros stage, which is located cephalically in the body. The pronephros then degenerates and the metanephros, which is more caudal, likewise disappears except for the persistence of its main excretory duct, the wolffian duct. The metanephros is the most caudal of these structures and develops from the mesonephric ducts as metanephric diverticula. These outgrowths then grow cephalo-laterad to connect with the metanephric tubules, which have developed from intermediate mesoderm. Thus, the definitive kidney differentiates from the lateral mesoderm of the urogenital ridge, and it is during this phase the ectopic kidneys develop from aberrant foci.

Radiographically, the superior kidney is dominant and the most rotated. The inferior kidney is always migratory with the ureter crossing the midline. The incidence of the anomaly diagnosed in this case is 1:2000 IVPs, according to Campbell, with a slight male preponderance. There are no pathognomonic clinical signs and symptoms; however, these patients do present with a pelvic mass. This ascribes to the purpose of presenting this topic, which is to reiterate the validity of performing an IVP on all patients being considered for exploratory laparotomy for a pelvic mass.



Figure 2

BIBLIOGRAPHY

A list of references is available upon request to the Radiology Department at Mercy Hospital, Des Moines, Iowa.

I REMEMBER WHEN—DO YOU?

I was in the service and assigned to a family unit, in addition to taking care of the Women Marines. In 2½ years, Dr. McGill and I delivered over 1,800 babies. In 1944 we had our only maternal fatality. This individual was the wife of a physician, and was very young and healthy up to the time of delivery. She came to the hospital with profuse hemorrhage. Blood was matched and given in massive amounts and the baby was delivered because she had considerable dilation, and I was able to deliver her quickly. The mother responded well to the transfusion and all of us thought we had done a good job. Bleeding stopped (the cause of hemorrhage was placenta praevia) and the patient appeared normal with blood count good. However, on the 5th or 6th day some ominous signs developed, mainly oliguria. Other findings developed and death occurred on the 10th day. Diagnosis, lower nephron nephrosis. The ironical aspect: Two weeks later Werner announced the findings of the Rh factor which has changed the picture with respect to the development of nephrosis; another discovery which has been of benefit to mankind in the last 50 years.—OTTO N. GLESNE, M.D., *Chairman, IMS Historical Committee.*

About IOWA Physicians

Dr. Robert C. Thompson will join **Drs. John J. Shurts** and **Robert J. Lynn** in their Eldora medical practice in July. Dr. Thompson is Cedar Rapids native now serving a rotating family practice internship in Akron, Ohio. . . . **Dr. Campbell F. Watts,** Cedar Rapids, is new medical staff president at St. Luke's Methodist Hospital. Other new officers are **Dr. Paul E. Orcutt,** president-elect; **Dr. Percy G. Harris,** vice president; and **Dr. John H. Lohmes,** secretary-treasurer. St. Luke's 1973 department chiefs are—**Dr. Plenny Bates,** anesthesia; **Dr. William R. Basler,** general practice; **Dr. Fred E. Abbo,** medicine; **Dr. Dean H. Bemus,** obstetrics; **Dr. Earl Y. Bickel,** orthopedics; **Dr. Kingsley B. Grant,** pathology; **Dr. Jack Reida,** pediatrics; **Dr. William J. Moershel,** psychiatry; **Dr. John Huston, Jr.,** radiology; and **Dr. Russell Conkling,** surgery. . . .

Dr. Pedro Ochoa has joined **Drs. Tomas Lopez** and **Joseph Rapagnani** in Keokuk. Dr. Ochoa is a 1960 medical graduate of National University of Mexico. He's served a rotating internship at Missouri Baptist Hospital in St. Louis, surgical internship at General Hospital in Buffalo, New York; residency in general surgery at Buffalo VA hospital; and residency in general surgery at Des Moines VA hospital. Dr. Ochoa also completed a fellowship at Lahey Clinic Foundation. . . . **Dr. G. T. Westly** is president of Cerro Gordo County Medical Society for 1973. Other new officers are—**Dr. H. L. Brenton,** Mason City, vice president; **Dr. J. H. Brinkman,** Mason City, secretary; and **Dr. W. K. Dankle,** Clear Lake, treasurer.

Dr. John Beattie is newly associated with **Drs. Kenneth Rodabaugh** and **Roy Wanamaker** in Tabor. Dr. Beattie received M.D. degree at University of Nebraska where he had a general surgery residency. He is Diplomate of American Board of Surgery and Fellow of American College of Surgeons. Dr. and Mrs. Beattie have purchased home in nearby Hamburg. . . . **Dr. R. F. Freeh** is new president of Newton's Skiff Memorial Hospital medical staff; **Dr. L. D. Norris** is vice president; and **Dr. E. M. Wittenberg** is secretary-treasurer. **Dr. J. W. Ferguson** is new president of Jasper County Medical Society, **Dr. S. E. Sybesma** is vice president; and **Dr. T. E. Kiernan** is secretary-treasurer. All are Newton physicians. . . . **Dr. Rafael A. Roure** has closed his Malvern office and is located in new Glenwood clinic facility. . . . Two U. of I. medical faculty, **Dr. Hans Zellweger,** and **Dr. Alfred Healy,** both of the Pediatrics Department, were speakers at recent March of Dimes State Teen Conference in Fort Dodge. . . .

Dr. W. E. Walsh, West Union, was honored recently by Palmer Hospital medical staff members and employees at a dinner in recognition of his new designation as senior consultant at Palmer. Dr. Walsh will continue his office practice in West Union and Hawkeye. He was presented plaque for 40 years of service to Palmer Hospital. . . . **Dr. Herbert E. Stroy,** Osceola, is included in 1972 edition of PERSONALITIES OF THE WEST AND MIDWEST in recognition of service to his community. . . . **Dr. Juergen Holl,** Clinton, is new president of Mercy Hospital medical staff. Other Clinton physician officers are—**Dr. Kerry Jensen,** vice president; and **Dr. Gregorio Lauz,** secretary-treasurer. **Dr. W. H. Griffith** and **Dr. Dale Mericle** are on executive committee. . . . **Dr. Everett A. Nitzke,** Des Moines pediatrician, is new chairman of the Iowa Chapter of American Academy of Pediatrics.



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. . . The seventh edition of textbook entitled, COMMUNICABLE AND INFECTIOUS DISEASES, co-edited by **Dr. Franklin H. Top, Sr.**, Professor Emeritus, Preventive Medicine and Environmental Health, U. of I. College of Medicine, has been published by C. V. Mosby Co., St. Louis. Other U. of I. faculty contributors to the book are—**Drs. Irving Borts, Alson Braley, Bruce Golden, Henry Hamilton, Kenneth MacDonald, Sergio Rabinovich, Christian Radcliffe** and **Ian Smith**. . . .

The following physicians are 1973 officers of Dallas-Guthrie County Medical Society: **Dr. William Castles,** Dallas Center, President; **Dr. William Seidler, Jr.,** Jamaica, Vice-President; **Dr. Keith M. Chapler,** Dexter, Secretary-Treasurer. Dallas County IMS delegates are **Dr. Eugene Lister,** Dallas Center, Delegate; **Dr. Perry Weigel,** Van Meter, Alternate. Guthrie County delegates are **Dr. William Seidler, Jr.,** Jamaica, Delegate; **Dr. Norman Krueger,** Casey, Alternate. Named to Board of Directors of Dallas County—Dr. Chapler, 3-year term; **Dr. Robert Deranleau,** Perry, 2-year term; **Dr. C. Robert Osborn,** Dexter, 1-year term. Named to Board of Directors of Guthrie County—Dr. Krueger, 3-year term; **Dr. Herbert Neff,** Guthrie Center, 2-year term; Dr. Seidler, Jamaica, 1-year term. Medical examiners for 1973-1974 from Dallas County are Dr. Chapler, Chief Medical Examiner; **Dr. Charles Fail,** Adel, Deputy; Dr. Lister, Dallas Center, Deputy; **Dr. John Royer,** Woodward, Deputy, and from Guthrie County—Dr. Neff, Chief Medical Examiner; Dr. Seidler, Deputy; and **Dr. Donald Taylor,** Stuart, Deputy. . . . **Dr. John C. Justin,** Mason City pediatrician, was guest speaker at November meeting of the Twins Club in Nevada. Dr. Justin's topic was "Who Is Likely to Have Twins and Why." He also spoke at a recent meeting of Mason City Junior Women's Club on "Poisoning in Children." . . .

Dr. John Doran, Ames, discussed "Knowing Yourself as You Grow Up," at meeting of Boone junior high students and parents sponsored by Boone County Y and Extension Service. . . . **Dr. Elmer Smith,** medical director, State Department of Social Services, was guest speaker at recent meeting of Pottawattamie-

Mills County Medical Society. Dr. Smith discussed new federal requirements bearing on nursing home patients. He explained new admission form, new classification of nursing homes according to level of care provided, and financing of patient care at the various levels. . . . **Dr. T. D. Throckmorton,** Des Moines, was elected president of the Western Surgical Association at group's annual meeting in Rochester in November. . . . **Dr. John Sunderbruch,** Davenport, was surprised with "This Is Your Life" treatment at December 6 Christmas Party attended by 70 employees of the Davenport Clinic. Friends of Dr. Sunderbruch from high school, medical school, the military, athletics, etc., were present. Davenport Clinic was founded in 1947 by Dr. Sunderbruch and a now-deceased associate.

Dr. J. R. Walker, Waterloo orthopedic surgeon, described "The Total Hip Procedure" at recent meeting of Association of Operating Room Nurses of North Central Iowa at Waterloo's Schoitz Memorial Hospital. . . . At recent Wapello County Medical Society meeting, **Dr. Martin D. Sokoll,** associate professor of anesthesia at U. of I. College of Medicine, discussed "Problems in Intensive Care and Inhalation Therapy." . . . **Dr. George L. York,** Clinton, has been elected to the Advisory Board of Clinton's Mercy Hospital. Dr. York has practiced general medicine in Clinton since 1960. . . . **Dr. Charles Johnson,** assistant U. of I. professor of pediatrics, was speaker at recent Fifth District meeting of Iowa Nurses Association in Cedar Rapids. . . .

Dr. R. L. Kniper closed his practice in Jesup February 1 and will join the Ross Loos Medical Group, a pre-paid organization, in Van Nuys, California. Dr. Kniper is a 1932 U. of I. medical graduate and practiced medicine in Jesup for almost 39 years. . . . New Boone County Medical Society officers are **John R. Anderson,** M.D., Boone, president; **Richard Vermillion,** D.O., Ogden, vice-president; and **John F. Murphy,** M.D., Boone, secretary-treasurer. . . . **Drs. Kaye Check** and **Steven Kruse,** Slater, have opened office in Madrid formerly occupied by **Dr. T. K. Leonard. . . . Dr. Donald F. Bomkamp,** Cedar Rapids, is 1973 presi-

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dent of CR Mercy Hospital medical staff. Other Cedar Rapids physicians named staff officers are—**Dr. Earl Y. Bickel,** president-elect; **Dr. Newell G. Ingle,** vice president; and **Dr. John P. Barthel,** secretary-treasurer. Named 1973 department chairmen are—**Dr. Robert Meyer,** anesthesiology; **Dr. Julius Pietrzak,** general practice; **Dr. Thomas McIntosh,** medicine; **Dr. Philip Crew,** obstetrics-gynecology; **Dr. John Koch,** orthopedics; **Dr. Dennis Charipar,** pathology; **Dr. James Reinertson,** pediatrics; **Dr. H. R. Hirleman,** radiology; and **Dr. E. L. Grandon,** surgery. . . .

Dr. J. J. Shurts, Eldora, is new president of Hardin County Medical Society. Other recently elected officers are—**Dr. T. C. Graham,** Iowa Falls, vice president; and **Dr. H. O. Stoutland,** Ackley, secretary-treasurer. Dr. Graham was named IMS delegate, with Dr. Stoutland as alternate delegate. . . . **Drs. George A. Paschal** and **E. F. Brown,** Webster City, have become active medical staff members at Hamilton County Public Hospital. Dr. Paschal recently re-opened his practice in Webster City after serving on medical staff at VA hospital in Des Moines for two years. . . . **Dr. Matt G. Sanders,** Fort Dodge, company physician for Geo. A. Hormel & Co. for 25 years, has retired. A graduate of Loyola University Medical School, Dr. Sanders is a past president of Webster County Medical Society as well as the medical staffs of both Mercy and Bethesda General Hospitals. . . .

Dr. Max Olsen, Minden, is new president of Pottawattamie-Mills County Medical Society. Other officers for 1973 include—**Dr. Robert Joranson,** president-elect; **Dr. Lynn Leibel,** vice president; and **Dr. Rosalie Neligh,** secretary-treasurer. Dr. Olsen is chairman of IMS Committees on Delivery of Health Services and Rural Health. . . . **Dr. Frank Rogers** has

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been elected president of Clinton County Medical Society; **Dr. Robert German,** vice president; and **Dr. L. G. Lauz,** secretary-treasurer. All are Clinton physicians. . . . **Dr. Yechiel Prusak,** Des Moines, is new associate member of American Society for Gastrointestinal Endoscopy. . . . **Dr. Frank Aledia,** Fort Madison, has become associated with **Drs. Tomas Lopez** and **Joseph Rapagnani** in Keokuk, as a consultant in urology. Dr. Aledia will remain at Valley Clinic in Fort Madison but will also maintain an office in Rapagnani-Lopez Clinic at Keokuk's St. Joseph Hospital. Dr. Aledia received M.D. degree at University of Santo Tomas, Manila, Philippines, in 1959. His urology residency was at University of Maryland Hospital. Before locating in Fort Madison, Dr. Aledia was assistant chief of urology section at Des Moines VA Hospital. . . . **Dr. Donna Drees,** Des Moines, has been named chief of staff at city's Northwest Community Hospital; **Dr. Roy Overton,** West Des Moines, is vice president; and **Dr. James Dolan,** also West Des Moines, is secretary-treasurer. Dr. Drees is believed to be the first woman to be hospital staff chief in Des Moines. . . . **Dr. Cyrus L. Beye,** Sioux City, has been named 1973 president of Woodbury County Medical Society. Other 1973 officers chosen are **Dr. John P. Tiedeman,** president-elect; **Dr. Stuart W. Leafstedt,** vice president; **Dr. Jack L. Bristow,** secretary; and **Dr. Sidney A. Cohen,** treasurer. All are Sioux City physicians. . . .

Dr. David F. Gordon, Des Moines, recently became board certified in Subspecialty of Cardiovascular Disease. Dr. Gordon had previously earned certification by American Board of Internal Medicine, a prerequisite to his new designation. . . . **Dr. Edwin D. Kennedy,** Mason City, was guest speaker at annual meeting of Wright County Medical Society. Dr. Kennedy spoke on "Anatomical Abnormalities Producing Symptomatic and Asymptomatic Pyuria." New Wright County officers are **R. A. Young,** M.D., president; **J. G. Lott,** D.O., vice president, and **C. P. Hawkins,** M.D., secretary-treasurer. Dr. Hawkins and **Alan Nelson,** D.O., were named delegates to 1973 IMS House of Delegates. . . . **Dr. H. F. Hsu,** professor, and **Dr. S. Y. Li Hsu,** associate professor, Department of Preventive Medicine, U of I. College of Medicine, recently visited the People's Republic of China after absence of 23 years and had their private, five-week tour turn into an "official affair." The couple was honored at reception given by Chinese Medical Association in Peking and was extended special invitation to visit area near Shanghai where schistosomiasis is endemic. Drs. Hsu were first U. S. medical personnel to visit area of disease in Communist China. The Hsus have been studying schistosomiasis for 20 years in attempt to develop vaccine for this debilitating disease which affects 200 million persons in Far East, Africa and South America. . . .

DEATHS

Dr. Arthur E. Crew, 97, a Marion physician for 60 years, died at a Marion nursing home December 5. Dr. Crew received M.D. degree at U. of I. College of Medicine in 1902. A former mayor of Marion and former state chess champion, Dr. Crew served as staff member at both Cedar Rapids hospitals. He was a life member of the Linn County Medical Society, Iowa Medical Society and American Medical Association.

Dr. Raleigh R. Snyder, 87, long time Des Moines otolaryngologist, died December 8 at Iowa Methodist Hospital. A 1906 graduate of Drake University, Dr. Snyder completed his postgraduate work at Rush Medical College in Chicago, New York Eye and Ear Infirmary, and Bellevue Hospital. Prior to retirement in 1967, Dr. Snyder had practiced in Des Moines for 58 years. He was a life member of the Iowa Medical Society and American Medical Association.

Dr. Evan A. Peterson, 75, of Burlington, died at his home December 15. Dr. Peterson practiced medicine in the Burlington area for 48 years. He was a member of the International Society of Tropical Dermatology, American Academy of Dermatology, Iowa Medical Society and American Medical Association.

Dr. Florence White, 85, died at her home in Rolfe December 22. Dr. White received the M.D. degree at Johns Hopkins Medical School in Baltimore, Maryland, where she also served her internship. She practiced medicine in Rolfe from 1914 until her retirement in 1966.

LIST YOUR WANTS

GENERAL PRACTITIONER NEEDED: Practice with complete freedom of action in a rural atmosphere? Office next to pharmacy, ready for occupancy, no unseen strings. Moville, Iowa, 15 miles east of Sioux City offers just such a chance. Contact Moville Community Development Association, Inc., Moville, Iowa.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

INTERNIST—Board qualified or certified internist to join seven-man multispecialty group in Iowa. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise family. First year $30,000, plus benefits; partnership in twelve months. Liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449.

VACANCY—created by sudden death of partner. General practitioner needed in town of 2,000. New medical clinic and very modern hospital serving a large area. Very lucrative practice with half of nights and weekends off. Close to Iowa Great Lakes. Excellent salary leading to partnership in 6 to 12 months. Call or write Ivan E. Brown, M.D., Hartley, Iowa 51346. Phone 712-728-2820.

FOR SALE—Thriving 25-year General Practice and fully equipped brick bungalow office building, corner lot, directly across street from open-staff hospital. Office fully air-conditioned, open firepiace in large waiting room, 4 examining rooms, second floor could be apartment and basement has been living quarters for 4 years. Equipment includes modern furniture plus 100 MA Fischer X-ray, Medcosonlator, Thermo-Fax, files with patient records. Would lease building and equipment if desired. Immediate possession. Call 515-792-1733 or write L. H. Koelling, M.D., 400 East 3rd Street North, Newton, Iowa 50208.

WANTED—INTERNIST, ORTHOPEDIST, OB-GYN, GENERAL SURGEON, ALLERGIST by expanding 20-man multi-specialty group in North Iowa. Preference to internists with either hematology or gastrocnterology subspecialty interest and to general surgeon with orthopedic interests. Fine family community of 32,000 serving regional needs of 250,000 citizens. Close to Mayo Clinic and University of Minnesota. First year salary; partnership beginning second year. Generous time away benefits. Pension program. All openings represent additions to existing departments. Write: "Info Pack" Park Clinic, Mason City, Iowa 50401 or call collect, 515-423-4120.

GENERAL PRACTICE OPPORTUNITY—Two GP's seek 3rd doctor to join group in northeast Nebraska city of 4,000. Available in summer of 1973. New facility under construction. Earnings will be tax sheltered through incorporation. For further information contact our Business Manager, P. O. Box 34240, Omaha, Nebraska 68164.

INTERNIST, PEDIATRICIAN, AND FAMILY PRACTITIONER NEEDED for 9-doctor multispecialty group including 3 GP's, 1 Internist, 2 Surgeons, 2 Obstetricians, and 1 Pediatrician. Early partnership, retirement program, competitive salary. Well established group, Midwest metropolitan area. Contact Forrest W. Smith, M.D., The Davenport Clinic, 1820 West Third Street, Davenport, Iowa.

9,000 POPULATION COMMUNITY in the center of the Great Lakes of Nebraska, with new hospital under construction, offers solo or group practice opportunities to general practitioners. Present hospital staff includes eight general practitioners, one general surgeon, two orthopedic surgeons, two pathologists, one radiologist, one urologist and one cardiologist. Contact Medical Recruitment Council, Box 337, McCook, Nebraska 69001. 308/345-3200.

DESIRE GENERAL PRACTITIONER to join busy solo practitioner in northwest Iowa city of 8,000 population, modern hospital with coronary care unit, State Mental Health Institute and variety of industries. Salary negotiable first six months then partnership if mutually agreeable. Practice involves—General Medicine, Pediatrics, OB, and some surgery. Contact: Thomas M. Gary, M.D., P.C., 212 West Bluff Street, Cherokee, Iowa 51012.

WANTED—INTERNIST—Board Qualified for Iowa group of two internists and two surgeons; own building; large modern hospital; midwest shopping and medical center; population, 30,000; well-balanced economy; 2 hours to 3 large cities; lake resort 10 miles away; hunting and fishing area; skiing 2 hours away; excellent school system; Junior College; art gallery; superb library facilities. Salary ($35,000-$40,000) depending on qualifications. Early partnership. Address your inquiry to No. 1485, Journal of Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED—Board Certified internist or family practice to join small progressive, university affiliated Independence Mental Health Institute. Duties consist of manning 20 bed medical unit, no surgery. 40 hour week. Surrounded by a number of colleges with cultural advantages. Pollution free, fishing and hunting abound in beautiful suburban rural area, but near Cedar Rapids and Waterloo. Teaching hospital, 3 year approved psychiatric residency program. Our staff on medical school faculty involved in clinical clerkships in psychiatry. Position available June 1 or there abouts. Salary $31,600. Write: S. M. Korson, M.D., Superintendent, Mental Health Institute, Independence, Iowa 50644.

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Medical Assistants

by TENORA MEYER, CMA

GOOD COMMUNICATION

We all realize the importance of good communication. Errors are usually due to faulty communication. Did we forget to relay an important message to our physician-employer? Let's not trust our memories, keep a note pad handy.

The obstacles to good communication include:

FEAR. Some people will not ask questions or make comments for fear of appearing dumb. We want patients to respect us but be sure you understand the question before you try to answer it.

LACK OF INTEREST. Let's not be so engrossed with our own interests and problems we can't take time to discuss the problems of fellow employees and others.

A COMMON LANGUAGE. When communicating with another talk in language he will understand. We must evaluate our listeners carefully if we are going to communicate with them effectively. In other words, we must ask ourselves what is our listener's state of mind, what is his educational background, is he familiar with the problem already and is he likely to greet the communication with resistance?

GIVE INSTRUCTIONS CLEARLY. When you give instructions, have a clear picture of what you want done. Express the order in specific terms and make sure the person understands exactly what is to be done and why.

TONE. Use the proper tone. This is extremely important. Tone is often overlooked but it is essential to good communications.

A LITTLE ANATOMY

Sometimes it helps to remember the names of parts of the body if we know how and why these names were chosen.

Examples: (1) The *deltoid* muscle is so named because it is triangular in shape, like (-oid) the fourth letter of the Greek alphabet, which is delta or Δ.

(2) *Sartorius* is Latin for tailor—looks like a patch. Thus muscle originates in anterior superior spine of ilium, inserts on medial side of proximal end of tibia, innervates femoral; action, flexes thigh and leg. The muscle looks like a patch.

(3) *Fibula.* Latin, "buckle." So named because it is the lateral and smaller of bones of the leg.

(4) *Patella*, from Latin, Patera, meaning a shallow dish or pan. The patella is shaped as a shallow dish—bone in front of knee.

(5) *Diaphragm*—From diaphragma, Greek—"partition-wall, barrier." So named as a partition separating abdominal and thoracic cavities—musculomembranous partition.

In relating the history of their illnesses, patients naturally do not always use medical terms. Match one of the medical terms in Group I with each less technical term in Group II.

Group I	*Group II*
1. Anorexia	After-birth .....
2. Decubitus ulcer	Bedsore .....
3. Epistaxis	German measles .....
4. Hematemesis	Head lice .....
5. Hordeolum	Lockjaw .....
6. Pediculosis capitis	Loss of appetite .....
7. Placenta and membranes	Nosebleed .....
8. Rubella	Sty .....
9. Tetanus	Vomiting of blood .....
10. Torticollis	Wryneck .....

Answers: 7-2-8-6-9-1-3-5-4-10

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

Librium® and (chlordiazepoxide HCl) concomitant us

SUB
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Health Sciences Library
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Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents, diuretics, anticholinergics and antacids.

Antianxiety effectiveness: Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling are not enough and until, in the ph judgment, anxiety has been reduce appropriate levels.

Effect on mental acuity: Usually proper maintenance dosage.

Safety: An excellent clinical reco use, the most common side effects re been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

in relief of clinically significant anxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Division of Hoffmann-La Roche Inc.
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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

President's Page



The medical ferment has a new dimension. Union advocates among Iowa physicians are stumping for followers. They believe this is the way to protect physician direction of medical care.

While no formal position has been taken by the Society on this approach, my personal reaction is an apprehensive one. I see professionalism and unionism as having little in common. To me organizing in the manner of a labor union poses a serious threat to medicine's centuries-old and coveted status as a profession.

The preservation of a climate where professionalism can flourish is an objective to be pursued with full vigor. My contention is that this should be done by a "profession" undergirded by time-honored medical and ethical standards, a profession which is dedicated to fostering the patient-physician relationship and to preserving and improving the total medical environment.

I see county medical societies, state medical societies and the AMA as best qualified and prepared to grapple with our destiny. My personal energy will be channeled in this direction. Each physician must evaluate this subject and make his own judgment.

K. E. Lister, MD

K. E. Lister, President

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IOWA Medical Miscellany

PSRO . . . Iowa Foundation for Medical Care has filed a letter with HEW signifying its desire and intention to function, if feasible, as a Professional Standards Review Organization in Iowa. Regulations spelling out PSRO functional details are awaited.

BC/BS MODERNIZATION . . . Organizational revamping of Blue Cross/Blue Shield was explained in recent mailing to Iowa physicians and hospitals. New arrangement continues independent policy-making boards for both bodies. Six joint board committees are established with equal representation. In new scheme Blue Cross President and Blue Shield Executive Director share responsibility for chief executive office. Finally, BC/BS operating departments will be streamlined into seven principal units.

UCR . . . Reported at January IMS Executive Council meeting was decision of Insurance Commissioner to extend availability of Blue Shield UCR coverage with few limitations. UCR claims are being paid in full better than 95% of the time. Commissioner has asked Comprehensive 365 contracts no longer be marketed. Such action will eliminate only Shield contract which discriminates between par and non-par physicians in payment approach. Unlimited UCR sale follows House of Delegates' recommendation. Other Insurance Commissioner actions: (1) He's decreed no legal basis exists for direct payment (assignment) of Blue Shield benefits to non-par physicians; and (2) He's said acceptance of a "prior agreement" by a participating physician abrogates his participating contract with Blue Shield and is therefore not permissible. Actions make important physician understanding of UCR's "prior agreement" and "hold harmless" provisions.

RESTORE BENEFITS . . . Inpatient psychiatric care coverage for up to 365 days is to be restored April 1 for participants in IMS Statewide Physicians Group Program. In 1971 benefits were reduced to 30 days by Blue Cross/Blue Shield. Letter explaining benefit restoration and slight additional cost is to be distributed to group's participants. IMS Group Insurance Committee has evaluated the matter.

PROFESSIONAL LIABILITY . . . Interest in an IMS-endorsed professional liability insurance program appears to exist. Basis for comment is early evaluation of brief survey of county society officers on malpractice. Question was asked: Would physicians in your area likely switch their coverage to an IMS-endorsed program with features at least equal to present coverage? Survey findings will be evaluated by IMS Medico-Legal Committee.

NOMINATING COMMITTEE . . . IMS Nominating Committee, selected at recent caucuses, will meet March 25 at 2 p.m. at Society Headquarters. Meeting is for purpose of choosing 1973-74 candidates for office and is open to interested members.

R & T SURVEY . . . Opinions of Iowa physicians on important medical issues were sought in February by DES MOINES REGISTER AND TRIBUNE Research Department. Random survey included 1,000 MD's and DO's. Findings will be reported in the REGISTER.

PHASE III . . . Medical profession has urged President Nixon to exempt physicians from Phase III economic controls. AMA has criticized discriminatory treatment of physicians in letter to the President. IMS has appealed to Iowa congressional delegation for relief.

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Postmaster, send form 3579 to the above address.

The Question Box



by ROBERT W. LINTHACUM, M.D.

Dr. Linthacum practices in Dysart, Iowa. His employment of a physician's assistant several years ago was noted widely in the press. He answers questions here about his experience.

You've utilized a physician's assistant in your practice for several years. How has it worked?

It has worked very well. We are able to care for more patients, there's always someone available in the community to provide medical care and for medical emergency; it has led to an upgrading of local first aid training and accident handling, and it has increased rapport with the youth. My assistant is accepted at the area hospitals and assists at surgery. He often rides in the ambulance with accident victims and begins supportive treatment on the way. Financially he's paid his way (through charges for procedures done) since his fourth month. I started his salary at $600 a month and now have it at $830 a month. Older nurses have been slower to accept him but the younger ones did so immediately and willingly.

Have your patients willingly accepted the performance of those duties you've assigned to your assistant?

There have been very, very few instances where patients did not want him to question them, examine them, or perform some procedure. Those who do object are almost always older persons. Many younger persons will ask to see the assistant. One area I have not used him is in examining female patients and this is a definite drawback. However, I have been surprised, many women will discuss menstrual and birth control matters with him.

Has the arrangement freed you to care for more patients?

We can definitely see more patients in the same time. It has not shortened my hours—except for those few patients he screens on my afternoon off and sometimes at night—but it has increased production. I would equate my assistant roughly to ⅔ of another doctor. I do not see every patient he sees. Many times he will simply report his findings, I determine the treatment, and he carries it out. I sign all prescriptions. He does his own chart entries. He handles 90% of the following: insurance and school physicals, application and removal of casts, skin suturing, removal of warts and sebaceous cysts, well-baby checks.

Has the matter of liability caused you much concern?

No. First of all he realizes which conditions he can handle and which he shouldn't. My seeing a patient and telling my assistant what to do specifically in front of the patient impresses everyone that whatever is done is done the way I would do it. My insurance carrier assured me any malpractice claim would be handled as if it involved one of my nurses or me; the ultimate responsibility is mine.

As one who has employed an assistant, would you endorse the activity which is now underway nationally and in Iowa to train, certify and/or license these individuals?

I would wholeheartedly recommend the employment of physician's assistants to work under conditions similar to mine. I believe they will prove to be especially useful in one and two-man offices in areas where doctors are scarce. I believe we should move faster than we have because we need the extra help now. Experience in my office and the Washington State Medex program has shown a man with extensive military training and experience does not need another long training program to fit him for civilian use.

1973 IMS Scientific Session

Approximately 300 members of the Iowa Medical Society family (physicians and wives) will participate March 29-April 2 in a unique, first-ever Society educational venture out of the state. The 1973 Iowa Medical Society Scientific Session will occur during this period in The Bahamas at Nassau's Paradise Island Hotel.

Experimentation with this type of scientific education program was authorized by the 1972 IMS House of Delegates. Since that time, Society officers, and more particularly, the 1973 Program Committee, have exerted extensive effort to arrange a profitable and pleasurable experience for those who take part.

"We are delighted with the program which has been arranged by the Committee under the chairmanship of L. J. Gugle, M.D.," said IMS President K. E. Lister, M.D., in preparing to lead the Iowa delegation. "The Committee members deserve our praise for their efforts in arranging an outstanding program with top-flight speakers. Much is in store both educationally and recreationally for those who will make the trip."

Nine out-of-state physicians are included in the 16-member faculty for the 1973 Scientific Session. The schedule provides for three full-morning sessions and has been approved for 11½ hours of credit by the American Academy of Family Physicians.

THE SCIENTIFIC PROGRAM COMMITTEE



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DR. GARBER

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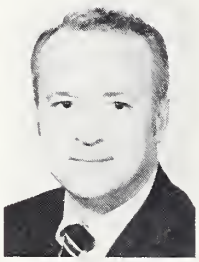
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RICHARD M. CAPLAN, M.D.
Iowa City, Iowa

KEITH A. GARBER, M.D.
Corydon, Iowa

HAL R. HIRLEMAN, M.D.
Cedar Rapids, Iowa

HERMAN J. SMITH, M.D.
Des Moines, Iowa



DR. HIRLEMAN



DR. SMITH

FRIDAY, MARCH 30

WELCOME

Kenneth E. Lister, M.D., President
Iowa Medical Society

ADOLESCENT PROBLEMS

GYNECOLOGY
Clifford P. Goplerud, M.D., Iowa City
Professor, Department of Obstetrics & Gynecology
University of Iowa College of Medicine

PSYCHIATRIC PROBLEMS
Beverley T. Mead, M.D., Omaha
Professor & Chairman, Department of Psychiatry & Neurology
Creighton University School of Medicine

ATHLETIC INJURIES
Michael Bonfiglio, M.D., Iowa City
Professor, Department of Orthopaedic Surgery
University of Iowa College of Medicine

SKIN PROBLEMS
Christian E. Radcliffe, M.D., Iowa City
Professor, Department of Dermatology
University of Iowa College of Medicine

PANEL DISCUSSION INVOLVING PRECEDING PHYSICIANS WILL INCLUDE A QUESTION & ANSWER PERIOD. JOINING PANEL TO CONSIDER TEENAGERS & AUTOMOBILES WILL BE PAUL GIKAS, M.D., PROFESSOR OF PATHOLOGY, UNIVERSITY OF MICHIGAN SCHOOL OF MEDICINE.

ROUNDTABLES WITH THE PROFESSORS

COMPLICATIONS OF MUSCULOSKELETAL TRAUMA
Dr. Bonfiglio

THE LABOR & DELIVERY AREA—THE OBSTETRICAL HIGH INTENSITY UNIT
Dr. Goplerud

QUICK & EASY MARRIAGE COUNSELING
Dr. Mead

DRY SKIN PROBLEMS
Dr. Radcliffe

USE & INTERPRETATION OF SEROLOGIC TESTS FOR SYPHILIS
Leslie Norins, M.D., Ph.D., Atlanta, Ga.
President, American Health Consultants
Former Chief, Venereal Disease Research Laboratory
Center for Disease Control, U. S. Public Health Service

USE & ABUSE OF X-RAY
Jerome F. Wiot, M.D., Cincinnati
Professor of Radiology
University of Cincinnati Medical School

ULTRASOUND: A NEW DIAGNOSTIC TECHNIQUE

Joseph H. Holmes, M.D., Denver
Professor of Medicine & Radiology
University of Colorado Medical Center

GONORRHEA: THE NEWEST ON DIAGNOSIS & TREATMENT

Dr. Norins

SATURDAY, MARCH 31

A DAY IN THE EMERGENCY ROOM ROUND-TABLE DISCUSSIONS

EMERGENCY RADIOLOGICAL PROCEDURES
Dr. Wiot

PERIPHERAL VASCULAR PROBLEMS
John L. Ochsner, M.D.
Ochsner Medical Clinic
New Orleans, Louisiana

COMA: DIFFERENTIAL DIAGNOSIS
Adolph L. Sahs, M.D., Iowa City
Professor & Head, Department of Neurology
University of Iowa College of Medicine

DRUG ABUSE: ACUTE REACTIONS
Dr. Mead

CARDIAC ARRHYTHMIAS
Don W. Chapman, M.D.
Houston, Texas

EMERGENCY ANESTHESIA
John Adriani, M.D., New Orleans
Professor, Department of Surgery
Tulane University School of Medicine

GASTRO-INTESTINAL HEMORRHAGE
James A. Clifton, M.D., Iowa City
Professor & Head, Department of Internal Medicine
University of Iowa College of Medicine

HOW TO SURVIVE YOUR AUTOMOBILE CRASH

Paul W. Gikas, M.D., Ann Arbor
Professor of Pathology
University of Michigan Medical School

ACUTE PULMONARY EDEMA

Dr. Chapman

WHICH CONVULSION IS WHICH?

Dr. Sahs

OBSTETRIC EMERGENCIES

Dr. Goplerud

SHOCK & RESUSCITATION

Dr. Adriani
Dr. Chapman
Dr. Ochsner

SUICIDE

Dr. Mead

SUNDAY, APRIL 1

CORONARY ARTERY DISEASE

MEDICAL
Dr. Chapman

SURGICAL
Dr. Ochsner
Moderator: Herman J. Smith, M.D., Des Moines
Medical Director
Iowa Lutheran Hospital

HAIR TRANSPLANTATION

Dr. Radcliffe

RECENT CONCEPTS REGARDING CIRRHOSIS AND HEPATITIS

Dr. Clifton

WHAT'S NEW IN MEDICINE

BLOOD LIPIDS—Dr. Clifton

ULTRASOUND IN TUMOR DIAGNOSIS—Dr. Holmes

PROSTAGLANDINS—Richard M. Caplan, M.D., Assistant Dean, Continuing Medical Education, University of Iowa College of Medicine

ACUPUNCTURE—Dr. Adriani

INTERVENTION RADIOLOGY—Dr. Wiot

NEUROLOGY—Dr. Sahs

OFFICE RECORDS/QUALITY OF CARE/CONTINUING EDUCATION—Dr. Caplan

RENAL BIOPSY: METHODS OF EXAMINATION WHICH SHOULD BE AVAILABLE—Dr. Gikas

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

ARE YOU EDUCABLE THROUGH YOUR EARS?

Are you a good listener? Good enough to soak up new information and put it to use after you've *heard* a voice, but seen no lips move, no gestures, no slides on the screen, no words or photos on the page? What I'm describing, of course, is continuing education via audio-tape. Many of you subscribe to the AMA AUDIO NEWS JOURNAL and to the well-known AUDIO-DIGEST, produced by the California Medical Association. Yes, many subscribe, but how many actually listen (perhaps the same proportion as read journals they subscribe to)? And how many of those who listen remember the information and put it to use at the appropriate occasion?

I'm not objecting, mind you. It suits the learning style of some people admirably (witness all the people who bought Brand-X soap powder after listening on the radio to Ma Perkins and Stella Dallas all those years). Audio-tapes are among the important contributions of modern technology that bring us educational material in a flexible format, to suit differing circumstances and learning styles.

Many physicians who subscribe to audio-tapes or receive them as promotional items from pharmaceutical companies like to listen while driving, reasoning they should put otherwise wasted time to constructive use. It's an admirable desire, and I wish them well. I have found it a little useful, a little fun, and a little frustrating. Useful because I got some new information, plus satisfaction that I was "keeping up" at the same time I was otherwise engaged. Fun because it seemed novel, and I got to keep pushing buttons and turning tapes while rolling down the highway. Frustrating because non-related visual stimuli or driving necessities would divert my attention entirely, and I'd realize I wasn't listening, or had lost the thread of the presentation. Of course, I simply re-wound some tape and started afresh. But it's a little like trying to write this column in my office during the day when patients, visitors, or telephone impinge every few minutes. Maybe practice would improve my skill. After all, I once learned through diligent effort to rub my head and pat my stomach at the same time.

My real concern is safety. When driving, the driving must take precedence over all else. If you were optimally attentive to what the tape was saying, you'd seriously risk your neck and maybe others' necks. So by necessity, we listen to the tape in a half-eared manner, with brain at the corresponding setting. Our ears-brain are dealing with drug action in cardiac arrhythmias, for example, while our eyes-brain-muscles deal with speedometer, bumps in the road, pedestrians, and rushing images of all sorts. It doesn't sound like a setting for optimal learning. But to all who can do it with success—more power to you!

Apart from these concerns about safety and distractions while driving, I think the audio-tapes and the increasingly available sound-slide formats represent a significant new approach to continuing medical education. You'll be hearing and seeing more about it. Give it a try!

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

SCIENTIFIC ARTICLES

Marijuana

JOEL D. TEIGLAND, M.D.
Des Moines

INDIANS CALL IT *bhlang, ganya* or *charas*. The Mexicans call it *mota, moto, mo-tul,* and *manteca*. In Central Africa it is known as *mbanzhe, mata, kwane,* or *dagga*. In America, it's known as *Mary Jane, grass, pot,* or a myriad of other names. Marijuana or hemp is what "it" is, or to be technically correct, the material is called *Cannabis sativa*. And in spite of the assumption by many that cannabis use was a product of the hippie, beat, or love generation, history indicates otherwise. The Chinese recorded the first adequate description and indicated that cannabis originated somewhere to the north of the Himalayan Mountains about 2737 B.C.

Cannabis failed to enjoy any significant popularity as an euphoriant in the United States until Mexican laborers began to bring their little bags of "mota" across the border in the early part of this century. The first significant endemic use of the drug in this country began in New Orleans, Louisiana. By 1926, New Orleans was saturated with cannabis users—and also with crime. River sailors took the habit from New Orleans and spread it up the Mississippi River. Four years later marijuana smokers could be found in almost all major U. S. cities.

Dr. Teigland is in the private practice of allergy in Des Moines.

DEMAND GROWS

In the thirties, the demand for cannabis became so intense Mexican laborers could not meet it. To prevent a shortage, shipments began arriving from Havana, Tampico and Vera Cruz. Marijuana importation became a full-time occupation for many individuals and the price jumped from an original $10 a kilo to nearly $50.

By 1936, the U. S. government took a serious look at the increasing use of the drug. Unfortunately, many misleading articles appeared and a whole series of myths were perpetrated on the public. Many of these myths exist to this day and are used to argue against the use of marijuana. These articles in 1936 caused public panic. A year later, the government issued a Federal Marijuana Tax and placed the drug under the Federal Bureau of Narcotics in an attempt to control its distribution and abuse.[1]

The laws passed in 1937 have had a significant effect in controlling the use of marijuana. These laws have also become the center of great controversy, especially in the last few years. Users of the drug now face the alternatives of either quitting or going underground.

With the coming of the civil rights movement, racial integration in the 50's, and the

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MARCH, 1973.

hippie movement in the 60's, social forces mingled black and white and users and non-users. Marijuana use increased. The spread of contemporary versions of the Hedonist or self-pleasure philosophy has encouraged many to experiment with the drug which is alleged to bring only pleasure and to have no ill-effects.

Today, as a result of marijuana use a new language has been born.[1] The more common descriptive terms for the user today are *pot-head* or *weed head.* They may also be called *roach bender, tea man* or *weed hound.* A marijuana cigarette is a *reefer, rocket, stick, joint* or *weed.* Once the cigarette has burned to a tiny butt it is known as a *roach.*

FOUR CATEGORIES

There are four states of *being* which characterize the relationship of a user of marijuana to society in general, and to his fellow users in particular. These are *cool, groovy, hip* and *square.*[1]

At the bottom of the social ladder we find the *square.* The *square* is us—he is "not with it," does not know "what is happening"; worse he probably does not realize his sad situation inasmuch as he is immersed in such activities as paying the rent, fixing the car and raising a family. With rare exceptions, people over 35 are considered *square.*

The "hip" individual is one who may or may not be out of the age group "where it's happening" and he may or may not "take part in the action" but he "knows where it's at" and is aware of the situation. He is not only savvy but probably "approves of the action." If he disapproves of drug activity he is a *straight hip.*

Near the top of the user's social ladder is the truly *groovy* individual. He is aware of the "scene" or the overall picture, as is the *hip,* but he differs in that he delights in "indulging in the action" with the rest of the users or *cats.* (The word "groove" incidentally may also be used to describe the ability of two or more people to communicate with seemingly total rapport.) Thus, as two people sit and "rap"—which is expressing serious and usually personal thoughts, preferably without hypocritical overtones—they find themselves in such accord that they begin to "groove."

The *cool* individual is at the top of the heap. He has it made because he has conquered, at least in his opinion, all of his "hang-ups." He not only knows "what's happening" but he knows "where it's at." He can "maintain" or "trip." He can "groove" or he can "cool it." You can ask him for an opinion and he lets you have it with no "hassle" or pretense.

SUPPLY

Where does a user get his supply? Basically, there are four ways to obtain marijuana—grow it, smuggle it over the border, acquire it from a user friend or group of users, or buy it.

The growing of marijuana is relatively easy. It can be grown in any kind of soil. In 1967, on a farm outside of Washington, D. C., one acre was seeded to marijuana and valued at about $100,000. However, the crop was never harvested after discovery by narcotic agents.

Smuggling marijuana across the U. S. border is hazardous. Even though customs and narcotic agents cannot possibly catch all marijuana coming from Mexico, they have been sufficiently successful to deter most people from taking this risk. A sentence of up to 10 years is a marked deterrent.

The most common way of acquiring a "stash" or "private supply" is to buy it or to "cop it." In talking to local youngsters, marijuana is easily available in Des Moines, and especially so in Iowa City. The drug is sold by the bag or box, sometimes termed nickel or dime bags. Sufficient marijuana is contained in a larger box to make about eight skimpy cigarettes. It is available by the lid or can which is about an ounce, and is usually sold in a plastic bag or in an old tobacco can. The price of a lid varies from $10 to $30. Rarely is marijuana sold by the pound or by the kilo. Hashish is available in its purified form and a gram may be purchased in Des Moines for about $7.00. This is an adequate supply for an entire evening for from five to seven people. (Hashish is obtained from the upper part of the hemp plant where the purest psychotoxic resin is produced.)

MANNER OF USE

John Rosevear,[2] in his book on "pot," described the process of smoking in great detail.

Once the *joint* or pipe is lit, it is to be kept in constant use. Each smoker drags deeply on it, filling his lungs and flushing it down with short breaths until the lungs are filled to capacity. He then sits and waits for the "stuff to have a chance" which means to hold the smoke as long and as deeply in the lungs as possible in order to have rapid and full alveolar transfer of the tetrahydrocannabinols into the blood stream.

The *roach* or the butt of the cigarette is a very valuable item and there are sophisticated jewel-bedecked *roach holders* to help in obtaining the maximum amount of this THC. Hashish is smoked in a similar way except a pipe is used.

When one decides to get high on marijuana, he can expect to feel the first sensations within minutes after smoking his cigarette. If the material is ingested, such as in a chocolate brownie, the effect will not occur for 30 minutes to one hour. There is no specific pattern of behavior to be anticipated since marijuana has both excitatory and depressant potential.

The singularly distinguishing feature of marijuana use is its unpredictability of effect for each person. This must be emphasized despite the assurance of some writers who imply that each *trip* on marijuana is identically the same, and thus predictable in effects.

The more common reaction to smoking marijuana is the rapid onset of a feeling of "inner joy" that is totally out of proportion to apparent motivation. The user soon finds himself "dreaming, relaxing, lolling in the delicious state of effortless nothingness produced by the drug." It is inaccurate, however, to assume that this is always the case. Some people become quite agitated during the early stages of the marijuana *trip*.

BEING HIGH

The state produced by marijuana is referred to as being *high*. If the intoxication becomes intense, the feeling is described as being *stoned*. If the user is alone, he may *trip off* and be quiet and drowsy. In company, he may be talkative and hilarious. Ideas begin to flit through his mind almost uncontrollably, flashing like bolts of lightning, often illuminating but seldom striking home. The flow of thoughts from some is so overwhelming that, try as they may, they cannot communicate their ideas. This usually strikes the user as hilariously funny, and he begins to titter the high-pitched, giggly laughter so common to marijuana users.

Some beginning users need an unusually large amount of marijuana to attain the state of being *high*. It is interesting that the experienced user usually requires less drug rather than developing a tolerance.

The basic personality of an individual is apparently not appreciably altered by using marijuana. His behavioral reactions may change however, because of reduced inhibitions and a changed interpretation of events.

The National Institute of Mental Health has recently submitted its first detailed report to Congress on "Marijuana and Health."[3] The Institute lists the subjective effects as follows: Alteration of time and space perception; sense of euphoria; relaxation; well-being and disinhibition; dulling of attention; fragmentation of thought; impaired immediate memory; altered sense of identity; exaggerated laughter and increase in suggestibility. Other less common effects are dizziness, a feeling of lightness, nausea and hunger. As doses higher than the typical social dose are consumed, more pronounced thought distortion may occur, including disrupted sense of one's own body, a sense of personal unreality, visual distortion, hallucinations and paranoid thinking. Rarely, individuals become quite anxious or panicky. Most users smoke to the point of being "high," which they find pleasurable and are able to control. Regardless of the strength of the marijuana or hashish, an experienced smoker apparently can titrate the amount to remain at about the same level of intoxication.

LIMITED FINDINGS

Objective findings from marijuana use are relatively few. One of the most consistent is an increase in the pulse rate. Another is reddening of the eyes. Dryness of the mouth and throat are uniformly reported. Although enlargements of the pupils was described in older literature, more careful study has indicated this does not occur. There have been no consistent changes in blood pressure. A wide range of physiological measurements including basal metabolism, temperature, respiratory rate and many others have all proved normal

with a relatively wide range of dosage. Mild bronchitis and even asthma have rarely been reported in chronic users.

Neurological examinations have revealed no major abnormalities during marijuana intoxication. Some investigators have found decreased strength in legs, hands and fingers with high dosage. Some decrease in hand steadiness and ability to maintain balance also occurs as the dosage is increased. Although users often have reported enhanced sensory awareness in the drugged state, objectively measurable improvement in visual or auditory acuity has not been found.

Recent experiments have strongly suggested that marijuana can impair complex mental performance. Tests involving short term memory were impaired, but interestingly, the performance at the lowest dose of marijuana was as poor as it was at the higher dosage.

ALCOHOL COMPARISON

From the standpoint of physical harm marijuana is probably not as harmful as alcohol. Psychologically, they are equally capable of producing erratic behavior and dependence. Dr. David Smith,[4] from the Haight-Ashbury Clinic in San Francisco and one of the most knowledgeable authorities on drugs, stated "alcohol is as dangerous as marijuana and marijuana is as dangerous as alcohol." He noted many young people distrust all drug information given to them by authorities since they believe the authorities follow a double standard when it comes to alcohol versus marijuana.

Marijuana does impair alertness and the combination of marijuana and alcohol—an increasingly popular combination these days—may increase the alcohol hazard.

It is impossible to determine how many accidents are related to the use of marijuana, as at present there is no test to determine if a patient is intoxicated or has used marijuana. One University of Iowa student reported she was capable of driving while under the influence of marijuana. She reported frequently riding with drivers who were intoxicated on marijuana and even though she had used no drugs at the time, she was unaware of any impairment in their driving. The marijuana users feel that alcohol is a more dangerous drug than marijuana.

CRIME RELATIONSHIP

Frequent press reports attribute crime to the use of marijuana. The initial introduction of marijuana into the U. S. through New Orleans in the 30's was in a crime infested area. Thus marijuana was thought to be closely associated with crime. Dr. Ausubel,[7] who is basically against marijuana, reports available evidence shows "that very rarely do major crimes follow upon the use of cannabis and that in incidences where they do, the relationship is an indirect one." He points out that still another reason for the association of marijuana and crime is its greater use in slum urban areas where delinquency rates tend to be high. In most cases of marijuana use in the United States it is unlikely the drug actually caused reported violence. Many experts feel that marijuana-decreased motivation will also decrease the likelihood for crime. In the report to Congress from the Department of Health, Education, and Welfare in January 1971, authors throughout the world, when comparing the properties of alcohol and marijuana, almost invariably conclude the former is more likely to be associated with violence.[3]

Dr. John Kaplan[8] points out most youngsters who use marijuana are of the culture of non-violence. They want to live and let live. He also stresses that users of marijuana normally do not have periods of black-out (that could occur under alcohol).

As one might expect in this younger age group, there is an association between marijuana use and antisocial behavior. Dr. Richard Blum[9] conducted a study on five college campuses in the late 60's and found that of 19% of the individuals who said they used marijuana, only 1% reported getting into fights while under the influence of the drug. About 94% of the total sample had tried alcohol and 8% of those individuals reported fights after drinking.

IMPACT ON SEX

Is marijuana an aphrodisiac? Does it cause sexual excitation and increase sexual powers? "It is true that some individuals experience a marked stimulation of sexual desires," says Dr. Robert Walton, "but in a great portion of other instances no such impulses are evident."[10] The effect again is very probably due

to the removal of usual restraints and, correspondingly, to the release of the more primitive impulses!

Some people actually take the drug in hopes that it will preserve, improve, or maintain their sexual powers. It is well to reflect that most of the marijuana users in this country are between the ages 14 to 25. This age span needs no aphrodisiac to stimulate either interest or capacity to perform. If men have the sex act in mind when they use the drug, they will probably move toward a partner. Most writers feel that marijuana is *not* a good aphrodisiac.

POPULARITY

How popular is marijuana? It has been estimated that between 12 to 20,000,000 Americans have tried this drug. One of the most extensive studies has been done in San Mateo, California, at the high school level. Twenty-seven percent of the high school freshman class had used marijuana during 1968, and this increased to 34% in 1969. Of the senior class, 45% of the boys had used it in 1968 and this increased to 50% in 1969. The statistics for the girls were somewhat lower. There was also a progressive incidence of use from the freshman to the senior class. In this study of those who had used marijuana, over 50% and up to 70% of this group had used it 10 or more times. High school studies elsewhere in the nation showed a considerably greater lag behind California. In one report, 16% of the high school boys and 8% of the high school girls in Tacoma, Washington had used marijuana. Similar findings were true in Portland, Oregon while in Vermont only 7% of those in urban and 5% in rural high schools admitted to smoking marijuana.[9]

Among our troops in Vietnam, three independent studies revealed that 32%, 31% and 35% had used marijuana.

Most of these studies in college and high school have involved the white middle class population. According to a recent report, the great majority of the Negro and Mexican-American youths of Oakland, California used marijuana. The use by Negro youth of one St. Louis high school reportedly was 47%.

A recent HEW report[3] found that single males are three times as likely to use marijuana as single females or married persons of either sex. Users tend to be disproportionately of the upper income or professional families. Those who are not affiliated with formal religions are more likely to have used marijuana. Users tend to major in arts, humanities or the social sciences rather than in other fields of education. More users than non-users have dropped out of school at some point. Also, the college oriented youngster seemed to be more marijuana oriented.

MIDWEST USE

Even though the incidence of use is supposedly higher on the coasts, studies in the midwest since 1969 hardly indicate the rates are any lower here. A Michigan study of 11 high schools in 1969, showed the rate of marijuana use varied from zero to 34% of the students.[11] The same year, the rates were 12% in one Utah study[12] and 23% in Wisconsin. A study at the University of Michigan in 1969 revealed a rate of 44% had "ever used" marijuana.[13] Apparently, a great increase in its use occurred between 1968 and 1969, but the overall increase between 1966 and 1971 has been fantastic.

There are no statistics available on marijuana use in Des Moines. It is known that a certain percentage of youngsters try marijuana at the junior high level and a higher percentage try or use marijuana at the high school age. The Iowa experts feel the rate at the University of Iowa is quite high and probably would compare with the University of Michigan, although statistical studies are not available. In conversing with Drake students, most regard the percentage of use as relatively low on that campus, and in conversing with students from the University of Iowa, most feel that the percentage is relatively high.

Many of our youth today—as well as some older persons—are asking the question, "Why not smoke marijuana?" One big reason given by pro-marijuana young people for its use is that it is safer than alcohol. Statistics would tend to bear them out. Only rarely and with large overdose have psychosis and severe effects occurred. Also, even though there have been 5,000 deaths per year directly related to alcohol, *no* deaths in modern times have been attributed to marijuana, even from marked overdosage.

POINTS OF CONCERN

In spite of the indication of harmlessness compared to alcohol, there are a number of points which must be considered by anyone contemplating the use of marijuana and by those already using the drug.

Possibility of addiction. If one smokes marijuana regularly, will addiction occur? According to the World Health Organization,[14] three major effects must be present in order to achieve true addiction. These are: psychologic dependence, tolerance, and physical dependence. Psychologic dependence is a state of mind in which the user feels so deeply that he must have the drug in order to be content that he is driven almost obsessively to repeat the use. This *does seem* to be one of the problems with chronic marijuana use.

Tolerance is the pharmico-physiologic reaction in which the user's body becomes accustomed to a given amount of the drug and requires more of the drug on the next occasion in order to achieve previous physical or psychological effects. Even though this occurs with some of the dangerous drugs such as amphetamines and with all the hard drugs, marijuana users frequently tend to use or need less to attain the same high.

Physical dependence is the body reaction to the continued presence of the drug so withdrawal symptoms occur when the drug is stopped. This also *does not* occur with marijuana.

The HEW report[3] indicated that certain attitudes and interests have been shown to be even more closely related to marijuana use than are the social demographic characteristics. None of these attitudes were true of only marijuana users or true necessarily of all of them. There is no indication that marijuana use caused them. They classified this as the "hang-loose ethic" characterized by the following: Dissatisfaction with own education and the system; opposition to the Vietnam war and the draft; approval of sexual freedom; feeling of communication gap between self and parents; anticipation of satisfaction from future leisure activities more than from work; participation in "happenings" and mass protests; belief in possible circumvention of law (not necessarily in breaking them).

The amotivational syndrome. More frightening, however, is another group of symptoms which have been described on a world-wide basis as associated with heavy chronic marijuana use. This is called the *amotivational syndrome.* In its extreme form this syndrome represents a loss of interest in virtually all activity other than the drug use, and tends to lead to social deterioration and drug preoccupation which might be compared to that of the skid-row alcoholic. The meaning of the amotivational syndrome is somewhat unclear. Some have used it as a blanket description to encompass a range of passivity as well as to include the behavior of numbers of young Americans who are, for varied reasons, dropping out of school and refusing to prepare themselves for more traditional adult roles.

PERSONALITY CHANGE

Dr. L. J. West[15] has described a clinical syndrome as a result of observation of regular marijuana users of three or four years duration. It is his clinical impression that many of these individuals show subtle changes of personality over a period of time which he describes as "diminished drive, lessened ambition, decreased motivation, apathy, shortened attention span, loss of effectiveness, introversion, magical thinking, derealization and depersonalization, diminished capacity to carry out complex plans or prepare realistically for the future, peculiar fragmentation in flow of thought, habit deterioration and a progressive loss of insight."

Possibility of psychiatric problems. Even more concerning is the report in the April 19, 1971 JAMA by two Philadelphia psychiatrists, Dr. Harold Kolansky and Dr. William T. Moore.[16] They reported on 38 young patients, ages 13 to 24, who were heavy marijuana smokers with no evidence of predisposition to mental illness. Since 1965, these doctors noted an increase in the number of patients with psychiatric problems beginning shortly after starting to use marijuana. Most of these patients smoked marijuana two or three times weekly and in general smoked two or more marijuana cigarettes each time. They consistently showed poor social judgment, poor attention span, poor concentration, confusion,

anxiety, depression, apathy, indifference and often slowed and slurred speech. Four patients attempted suicide. Four patients had marked psychosis. Six patients had deterioration in school work, inability to concentrate, gradual decrease in academic standing, apathy, indifference, and withdrawal from social activity. Thirteen patients showed marked sexual promiscuity. It was observed that when the patients stopped using the marijuana, the adverse effects gradually disappeared and the patients resumed more normal behavior.

LONG TERM USE

Long term problems. Long term effects of marijuana are not certain at this time. The Indian Hemp Drugs Commission in 1892 reviewed all admissions to a mental hospital for one year. Of 1,344 admissions the commission found that marijuana consumption could be considered to be a possible factor in no more than 7 to 15% of the cases. A similar study by Dr. Chopras,[17] from 1928 through 1939, revealed that only 600 cases admitted to Indian mental hospitals could be traced to the use of marijuana. At that time, the number of users of marijuana of all types was extremely high throughout India.

Recently a case of long use came to light in a small town in California. A 60-year-old school teacher was recently fired from her job because she signed an affidavit to help a young friend who was arrested for selling marijuana. She admitted to smoking marijuana daily for 18 years and found the experience was quite beneficial, relaxing and a great aid in staying up late to correct papers. Interestingly, she was able to discontinue the drug immediately with no side-effects.

STEPPING STONE

A first step to other drugs. Does the use of marijuana lead to the use of more dangerous drugs? Maybe. It depends upon the person and circumstances. In the ghetto areas and during the hippie movement on the west coast, marijuana was only one of the drugs being used. John Rosevear,[2] a pro-marijuana author, feels there is no more relationship to dangerous drugs and marijuana than to dangerous drugs and alcohol. Dr. Blum,[9] in 1968, stated there is still no evidence of a causal stair-step effect, i.e., marijuana leads to heroin. Evidence does indicate that initial interest in drugs can lead to an expanded drug interest and commitment to a life style in which drugs play a predominant role.

In one college study it was found that 100% of the daily marijuana users had used other drugs. Eighty-four percent of the weekly marijuana users had used other drugs, 20% of the experimenters had used other drugs and none of the marijuana abstainers had used other drugs.[9] Other drugs in this case referred to hallucinogens, barbiturates, speed and amphetamine and hard drugs. It is worrisome that marijuana users have contact with pushers who might attempt to sell other drugs. In the current group of marijuana smokers, contact with pushers is apparently minimal as marijuana and hashish are usually obtained from peers.

THE LAW

Marijuana use and the law. Dr. John Kaplan in his book, MARIJUANA, THE NEW PROHIBITION,[8] discusses the laws and marijuana in great detail. He is currently a professor of law at Stanford University Law School and was appointed by the California Legislature in 1966 to suggest revision in the state's drug laws. In his study in California during 1968, Dr. Kaplan found that approximately a quarter of all felony complaints were for violation of marijuana laws. More than 34,000 adults and 17,000 juveniles were arrested for marijuana offenses. California state and local government agencies in that year spent $72 million enforcing the marijuana laws.

In recent years, sporadic attempts to change the law have been made throughout the country. The main objection to current laws is the felony charge for possession of marijuana. Dr. Kaplan, in his extensive review of the California laws, feels changes must be made. First, he feels that simply removing all controls from marijuana use is not satisfactory. Secondly, he suggested the possibility of making marijuana a prescription drug and turning the control over to physicians. Inasmuch as it has no medicinal properties, few physicians would accept prescribing a drug for recreational purposes. He describes a third measure in which the selling of marijuana would remain criminal

but not the use or the small scale possession of the drug. One of the problems with this method is determining if the sale of a few cigarettes would classify a youngster as a pusher.

The last suggestion would be the "licensing model." Under this model, marijuana would be sold essentially the way alcohol is sold, by licensed dealers selling without impediment as long as certain conditions are met. A licensing system would impose standards of purity and potency while, within limits, the price could be controlled through taxation.

Licensing the sale of marijuana in this way might also have the desired effect of restricting the underground drug market that today makes available and even encourages the use of drugs far more harmful than marijuana. One of the arguments against this type of law is that it will lead to increased use of the drug.

The AMA House of Delegates adopted the following recommendations at the 1972 annual meeting in San Francisco: "Policy Statement on Marijuana: The AMA House of Delegates does not condone the production, sale, or use of marijuana. It does, however, recommend that the personal possession of insignificant amounts of that substance be considered at most a misdemeanor with commensurate penalties applied. It also recommends its prohibition for public use; and that a plea of marijuana intoxication should not be a defense in any criminal proceeding."

The recent new Iowa Drug Law has eliminated the felony charge for possession of marijuana and has made it a misdemeanor which is more in keeping with recommendations from experts in this field. Most experts feel that marijuana will be completely legalized within the next five years. It is the initial impression this change might come through the efforts of current marijuana smokers who at that time will be our lawmakers. However, knowledgeable people feel the increased use of marijuana among older citizens will force these changes, as will the political pressure for taxation on marijuana. Currently, several of the tobacco companies are investigating the possibility of manufacturing marijuana cigarettes.

Much more research is needed on the health implications of marijuana use. It should be emphasized that the issue of marijuana use in our society is complex and also involves moral, philosophical and legal questions which are unlikely to be resolved by scientific research. It is essential that there be adequate understanding of the health implications to the millions of Americans using marijuana.

Current studies are now directed toward the cardiovascular system, liver, gastrointestinal, lung and brain functions and the neuroendocrine effects. While such research may provide important clues, the most important of these can only be answered by careful observation and testing of the many users who are, in effect, experimenting on themselves. To date, long-term studies have not generally been possible with American populations.

Finally, it is important to develop effective methods of prevention and education that are likely to deter individuals of all backgrounds and at all levels of risk from adopting pernicious patterns of marijuana use or of other drug abuse in our society.

REFERENCES

The references noted in this article are available from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

DIABETES WORKSHOP

A comprehensive learning experience for diabetic patients and their families will be provided at 2 p.m., Saturday, April 7, through 2 p.m., Sunday, April 8, at the YMCA Camp near Boone, Iowa. There will be small discussion groups and many visual aids will be used. The cost will be $7 per person, which includes three meals and lodging. Participants may bring their own campers if they wish.

Physicians who have diabetic patients are invited to have them contact Vivian Murray, President, Iowa Diabetes Association, Route #3, Ames, Iowa 50010. Reservations must be received by March 15, 1973.

Hyperthyroidism With a Functioning Nodule

PAUL VANDER KOOI, M.D.
Orange City

In 1913, Plummer[1] postulated that thyrotoxicosis could be due to hyperfunctioning thyroid adenomas. Cope *et al*[2] verified this premise in 1947. The symptomatology of Graves' disease is well known to physicians, but hyperthyroidism due to a hyperfunctioning nodule is not. This paper will describe one such case, discuss its pathophysiology, its anesthetic complications and its successful treatment with radioactive iodine.

CASE RECORD

A 41-year-old Caucasian, Gravida 2, Para 2 female was admitted for pelvic laparotomy on December 28, 1969 upon finding of a pelvic mass during a routine physical examination.

The patient reported completely normal menses. She had had an appendectomy at age 20 and a tonsillectomy and adenoidectomy as a child. She did present a history of "tiredness." Otherwise her health had been good.

Physical examination on admission demonstrated a blood pressure of 144/86, temperature 98.6 degrees, pulse 100 and regular. There was a question of a diffusely enlarged thyroid. There was a left adnexal mass 8 cm in diameter. The rest of the examination was normal.

The patient was given meperidine 75 mg and atropine 0.4 mg intramuscularly preoperatively. Her pulse increased to 138 and was regular. The blood pressure was 160/80 on arrival in the operating room. The tachycardia was regarded as secondary to anxiety and was expected to subside after induction of anesthesia. She was given 250 mg of thiopental intravenously followed by 50% nitrous oxide, 50% oxygen and 2% halothane. Upon reaching stage three anesthesia, the patient received 50 mg of succinylcholine intravenously for intubation. An endotracheal tube was passed. Subsequent to induction, the blood pressure increased to 180/80 and the pulse to 180/min. The clinical assumption of paroxysmal atrial tachycardia was made, but there was no response to carotid sinus massage. Slow intravenous administration of 1.0 mg of digoxin had no effect on the tachycardia. Initially she was given gallamine for muscle relaxation, but this was altered to d-tubocurarine for its sympatholytic effect. Her pulse continued rapid and regular until she suddenly suffered cardiac arrest which, on monitor, was ventricular fibrillation. Successful resuscitative efforts were begun within 20 seconds of clinical arrest. The pulse dropped to 136/minute and she breathed spontaneously.

Postoperatively, the patient had runs of atrial fibrillation, nodal tachycardia and atrial tachycardia. We became suspicious of occult hyperthyroidism and on direct questioning, she told of having an "internal goiter" diagnosed 12 years ago. Her physician at that time is reported to have jokingly told her she was the "lady with the pounding pulse." Tests for hyperthyroidism were drawn and she was placed on propranolol hydrochloride, propylthiouracil and SSKI. She proceeded to make an uneventful recovery.

Dr. Vander Kooi is in the private practice of general medicine in Orange City.

Specific pertinent laboratory data were as follows: Cholesterol 192, 24 hour urinary catecholamines 41 mcg for 24 hours (normal up to 100 mcg), PBI 13.0 mcg %, T_3 47% (normal 24 to 36% uptake) and T_4 12.5 mcg % (normal 5.8 to 11.9 mcg %).

The patient was discharged on propylthiouracil 100 mg every six hours and propranolol 10 mg every six hours. The pulse gradually slowed down, but she then developed a rash and was switched to methimazole. Thyroid scan demonstrated complete suppression of activity of the right lobe and the consulting internist recommended she have the hyperfunctioning nodule resected.

She was continued on methimazole 5 mg three times a day and then given iodine prior to surgery. The patient was brought to surgery again four months after the initial cardiac arrest. Her pulse this time preoperatively after 0.4 mg of atropine was 120/min., blood pressure 120/70. She was given a small dose of thiopental and then slowly induced with 50% oxygen, 50% nitrous oxide, and increasing concentrations of halothane. Vital signs remained stable. She was monitored throughout. She was given 50 mg of succinylcholine intravenously and immediately developed runs of ventricular tachycardia. The anesthetic gases were shut off immediately. She was given 100% oxygen with return to sinus rhythm.

Methimazole 5 mg three times a day was continued and PBI was 5.5 mcg %. Radioactive iodine uptake was 12.2% at four hours and 18.3% at 24 hours, and again she showed almost complete activity in the left lobe. She was given 15 millicuries of radioactive iodine.

One month following this, her PBI was 6.3 mcg %, T_3 31% (normal 24 to 36%) and free T_4 was 0.64% (normal up to .75%). Four months later her PBI was 6.9 mcg %, T_3 31% and free thyroxine index 0.70. Five months later, the 24 hour I-31 uptake was 16.4%. The scan showed activity in the right lobe. Six months later, the patient was seen and said her tiredness was gone and she had never felt better.

DISCUSSION

The above patient is typical of the syndrome of hyperthyroidism secondary to a hyperfunctioning thyroid nodule. She presented with a long standing complaint of tiredness rather than nervousness and absence of exophthalmos. She had no diffuse thyroid enlargement or weight loss. The diagnosis of the condition eluded the referring physician, the surgeon, the anesthesiologist and several other physicians.

TABLE I
COMPARISON OF ADENOMAS AND GRAVES' DISEASE

	Toxic Adenomas	Graves' Disease
Age	Older	Younger
Onset	Insidious	Often acutely
Symptoms	Tiredness, racing pulse	Nervousness, hyperactivity, weight loss
Appearance	Quiet, no emotional lability	Restless, emotional lability
Exophthalmos	Absent	Common

Table I summarizes the contrast between the clinical picture of toxic adenomas and Graves' disease.

The pathogenesis of the hyperfunctioning nodule is not definitely known. However, TSH and long-acting thyroid stimulator have not been demonstrated in patients with a hot nodule in studies reported by McKenzie[4] in contrast to Graves' disease. Although many hot nodules are autonomous, some are at least partially TSH dependent. Greene and Farran[5] studied 46 patients with hot nodules. The patients were treated with levothyroxine for at least three months. Sixteen patients had a decrease in the size of the nodule, but 30 did not.

Interestingly, this author has had two patients with symptoms identical to patients of adenoma who were receiving excessive dosages of thyroid and increased the dose of thyroid because they continued to be "tired" and their symptoms resolved on lowering the dose of thyroid. If one has a patient with a TSH independent hyperfunctioning nodule and is euthyroid, it is also possible to produce hyperthyroidism by using thyroid hormones in an attempt to suppress the nodule. It is also of interest that the hormonal activity of the nodule appears to be dependent solely on its size. No nodules less than 2.5 cm diameter have been associated with hyperthyroidism and most were greater than 3 cm.

It appears the symptoms of hyperthyroidism associated with the hyperfunctioning nodule

derive from the increase in circulating thyroid hormone in contrast to Graves' disease. Thus, in treating hyperthyroidism due to a hyperfunctioning nodule, one cures the patient. By contrast, in the treatment of Graves' disease, one only controls a facet of the disease.

What is the proper treatment for hyperthyroidism due to the hyperfunctioning nodule? Both surgical resection and radioactive iodine effect the ablation of the hyperfunctioning adenoma. Suffice it to say there are two schools of thought and both treatments have been effective.

On this reported case, the patient had definite anesthetic complications, both while hyperthyroid and after being made euthyroid by drug therapy. Unfortunately, the patient was not monitored in the first operative period. She developed ventricular tachycardia immediately after the injection of succinylcholine. The author[6–8] could find no other references to such sensitivity to succinylcholine in the literature.

The patient was subsequently treated with a dose of 15 millicuries of I-131 and on the basis of clinical response, thyroid scan and thyroxine blood levels was rendered euthyroid without mishap.

SUMMARY

A case of hyperthyroidism secondary to a hyperfunctioning thyroid nodule is presented. The clinical picture and pathophysiology is reviewed. The development of ventricular tachycardia and ventricular fibrillation during surgery is described. It is suggested that ventricular tachycardia occurred after administration of succinylcholine. Subsequent successful treatment with radioactive iodine would indicate this may be the safer method of treatment for this condition.

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4. McKenzie, J. M.: Review: pathogenesis of Graves' disease: role of long-acting thyroid stimulator, J. Clin. Endocr., 25:424-461, 1965.

5. Greene, R., and Farran, H. E.: On single "hot" nodules of thyroid gland. J. Endocr., 33:537-538, 1965.

6. Silverstein, G. E., *et al:* Natural history of autonomous hyperfunctioning thyroid nodule. Ann. Intern. Med., 67:539-548, 1967.

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Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

March 4-7	Intensive Course in Pediatric Nutrition
March 6	Renal Disease Conference (Davenport)
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March 7	Ophthalmology Clinical Conference
March 9-10	Postgraduate Course for Physical Therapists—"The Knee"
March 13	Renal Disease Conference (Boone)
March 16	Renal Disease Conference (Mt. Pleasant)
March 20	Renal Disease Conference (Council Bluffs)
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April 9-12	Training for Physicians in Coronary-Care-Unit Techniques
April 9-12	Echo-Ophthalmography Course and Workshop
April 19	Renal Disease Conference (Sioux City)
April 19-21	In-House Conference for Practitioners
April 24	Renal Disease Conference (Waterloo)
April 24-25	The High-Risk Obstetrical Patient, Fetus and Newborn
April 28-29	Dissection Course in Orbital Anatomy
May 10-12	Iowa Eye Association

Unless otherwise specified all courses and conferences are held at The U. of I. College of Medicine, Iowa City.

Leukemoid Reaction In Acute Lymphoblastic Leukemia: A Response to Chemotherapy

DAVID T. KAUNG, M.D.
Iowa City

KRUMBHAR[1] in 1926 described leukemoid blood pictures in various clinical conditions. Included was a case of mustard-gas poisoning. The patient had markedly depressed granulocyte levels (52 PMN's per mm^3) and many myelocytes in the peripheral blood. Since then other drugs have been reported to cause leukemoid reactions.[2-5] The most dramatic case was that reported by Levene & Weintraub.[6] Recovering from dapsone induced agranulocytosis, the patient presented a clinical and laboratory picture indistinguishable from acute myeloblastic leukemia. The marrow was hypercellular with 80-90% myeloblasts and promyelocytes. Recovery was prompt without antileukemic treatment. Since severe bone marrow depression and granulocytopenia are frequently induced by antileukemic agents, one wonders why leukemoid reactions or pseudoleukemic reactions are not commonly seen in patients with acute leukemia. This report presents a patient with acute lymphoblastic leukemia who showed repeated leukemoid reactions following each course of intensive chemotherapy.

PATIENT SUMMARY

R. C., a 31-year-old farmer, was first admitted to the VAH in Iowa City with a history of weakness, lethargy and pallor of two weeks' duration. One week before admission he had a fever of 39.5°C and was treated with penicillin. His peripheral blood smears showed abnormal cells and so he was referred to the VA Hospital for further evaluation.

Physical examination showed a pale white obese man in no acute distress. Hemorrhages and exudates were present in both ocular fundi. A few 0.5 cm lymph nodes were palpable in the left cervical area. The liver was not enlarged but the spleen was palpable 2 cm below the left costal margin. There were no evidences of mucosal or skin hemorrhages.

Laboratory examinations showed Hgb 5.0 gm%, platelets 51,000 per mm^3, Wbc 12,000 per mm^3 with 77% blasts. Blood chemistries and urinalysis were normal. A bone marrow aspiration shortly after admission showed a hyperplastic marrow with almost complete replacement by blasts with prominent nucleoli and very scanty cytoplasm (Figure 1). PAS stain showed fine and coarse granules in the cytoplasm typical of lymphoblasts.

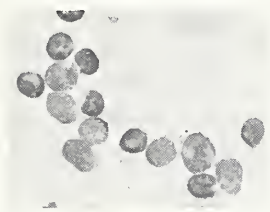
On 1-6-71 the patient was started on antileukemic therapy which consisted of cytosine arabinoside 15 mg/kg by IV push daily × 5, vincristine 0.025 mg/kg IV once a week × 3, and prednisone 1.0 mg/kg/day orally in three divided doses for 21 days. The peripheral blood and bone marrow responses are indicated on Figure 2 and Table 1. There was prompt recovery of platelets, Wbc, and granulocyte counts following nadirs of 13,000, 700, and 120 per mm^3 respectively. The bone marrow specimen on 1-21-71 was very hypocellular. However, erythroid and myeloid regeneration were already in evidence. Five days later the bone marrow showed further myeloid regeneration and maturation and there was no evidence of an acute lymphoblastic leukemic process.

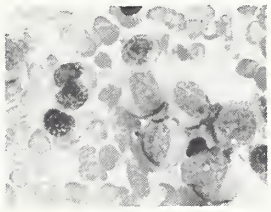
Dr. Kaung is an associate professor in the Department of Internal Medicine at The University of Iowa College of Medicine. He is also affiliated with the Medical Service of the Veterans Administration Hospital in Iowa City.

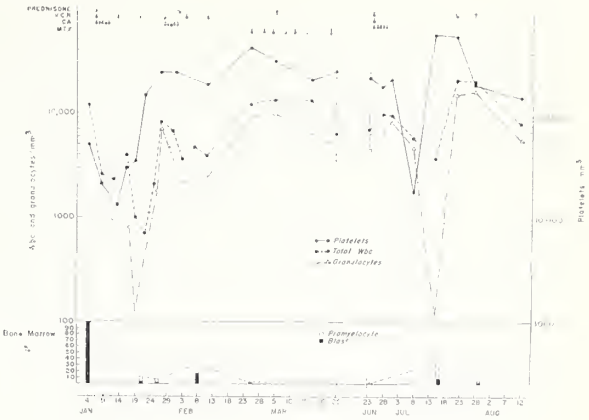
Figure 1. (Lower Left) Bone marrow aspirate showing clumps of lymphoblasts. (Wright-Giemsa stain, X3200).

Figure 2. Clinical course (right hand column).

Figure 3. (Lower Right) Bone marrow aspirate showing predominance of immature myeloid cells (Wright-Giemsa stain, X3200).







The second course of therapy was started on 1-28-71. The dose of cytosine arabinoside was reduced to 7.5 mg/kg daily × 5. Prednisone was inadvertently also reduced and tapered on 2-1-71. The fall of Wbc and granulocyte counts was modest and recovery was prompt. The bone marrow specimen on 2-8-71, however, showed a definite increase in blasts (17.5%) with few myelocytes, metamyelocytes, and bands but adequate PMN's. Since there was also a definite increase in promyelocytes (14.0%) and evidence of maturation toward the myeloid series, it was felt the marrow picture represented a reactive phase to chemotherapy rather than a relapse of ALL. Seventeen days later, the marrow had indeed returned to normal.

TABLE I

BONE MARROW AND PERIPHERAL BLOOD DATA

Dates:	1-5-71	1-21-71	1-26-71	2-8-71	2-25-71	6-24-71	7-16-71	7-26-71
Bone Marrow*								
Cellularity	↑	↓	↑	↑	↑	N	↑	↑
Megakaryocytes	↓	0	N	N	N	N	N	N
Rbc/100 Wbc	2	612	440	654	22	49	111	15
Blasts	99.2%	3.5%	1.0%	17.5%	0.5%	0.0%	9.5%	1.0%
Promyelocytes	0.0%	7.5%	6.5%	14.0%	1.0%	0.5%	23.0%	5.0%
Myelocytes	0.0%	7.0%	17.0%	1.5%	24.5%	10.0%	35.0%	14.0%
Metamyelocytes	0.0%	2.5%	17.5%	0.0%	16.5%	20.0%	14.5%	16.0%
Bands	0.8%	3.5%	14.0%	1.5%	23.0%	24.0%	3.5%	11.0%
PMN's	0.0%	1.5%	21.0%	26.5%	29.0%	33.5%	1.0%	46.0%
Eosinophils	0.0%	2.0%	0.5%	7.5%	1.5%	3.0%	2.0%	1.0%
Lymphocytes	0.0%	70.5%	19.5%	24.0%	3.0%	9.0%	11.0%	6.0%
Others	0.0%	2.0%	3.0%	7.5%	1.0%	0.0%	0.5%	0.0%
Peripheral Blood**								
Hgb. gms	5.0	7.1	7.2	6.6	10.7	14.6	11.7	14.0
Wbc	12,000	1,100	3,700	3,500	12,900	7,300	3,800	21,800
Blasts	76.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%
Promyelocytes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%
Myelocytes	0.0%	0.0%	1.0%	0.0%	5.0%	0.0%	9.5%	1.0%
Metamyelocytes	1.0%	0.0%	1.0%	0.0%	3.0%	0.0%	10.5%	1.0%
Bands	3.0%	3.0%	3.0%	0.0%	5.0%	1.0%	2.0%	3.0%
PMN's	10.0%	13.0%	55.0%	65.0%	67.0%	61.0%	8.5%	72.0%
Eosinophils	0.0%	2.0%	0.0%	3.0%	0.0%	4.0%	0.0%	0.0%
Lymphocytes	10.0%	79.0%	37.0%	32.0%	15.0%	29.0%	51.5%	21.0%
Others	0.0%	3.0%	3.0%	0.0%	5.0%	5.0%	8.0%	2.0%
Rbc/100 Wbc	5	56	13	11	2	0	11	1

* 500 white cells counted.
** 200 white cells counted.

The peripheral blood showed a transient mild leucocytosis and then also returned to normal. The patient was by then in complete bone marrow and clinical remission.

From 2-25-71 to 3-26-71 the patient was maintained on oral methotrexate (Mtx) 20 mg twice weekly. On 3-26-71 a third course of therapy consisting of CA 15 mg/kg IV × 5 and prednisone 1.0 mg/kg/day was given. Vincristine was withheld because of peripheral neuritis of moderate severity. Again there was a transient leucopenia (3,000 per mm^3) and marked granulocytopenia (0% PMN) followed by a transient leucocytosis of 16,000 per mm^3. The bone marrow specimens before and 40 days after the first dose of therapy were completely normal.

Following another 2½ months of Mtx maintenance, the patient was started on a fourth and complete course of CA, vincristine, and prednisone on 6-25-71. The bone marrow specimen was normal before therapy but showed 9.5% blasts and 23.0% promyelocytes on 7-16-71, 20 days after the first dose of CA (Figure 3). The lowest Wbc count was 3,800 per mm^3 and the lowest granulocyte count was 115 per mm^3. Immature white cells were also seen in the peripheral blood. The shift to the left was again followed by prompt recovery of the platelet and granulocyte counts and another period of transient leucocytosis. Thirty days following the beginning of the fourth course of therapy, the marrow was again within normal limits. The patient remained in complete remission.

During the first course of therapy the patient received four units of blood which raised his hemoglobin from 5.0 gm% to 7.1 gm%. Subsequently there was a steady spontaneous rise until normal limits were reached approximately three months after admission. With each course of therapy the marrow showed marked megaloblastosis and the peripheral blood showed transient drops of Hgb level.

COMMENT

The strategy of current acute leukemia treatment consists of the use of a combination of drugs to maximally suppress the leukemic cell population, and to maintain the remission status by various regimens to keep the leukemic cell population suppressed.[7, 8] To effect a complete remission, it is frequently necessary to give repeated courses of chemotherapeutic agents at intervals of two to three weeks in an attempt to progressively reduce the leukemia cell load without cumulative bone marrow depression.[9] The cellularity of the bone marrow and the percentage of blasts or leukemic cells are the major criteria which determine the state of marrow remission and the need for further therapy.[10–14] In the case reported here, bone marrow specimens, obtained after the second and fourth courses of induction therapy, were normal to slightly hypercellular. The definite increase of myeloblasts and promyelocytes to 31.5% and 32.5% would have indicated a M_3 status (blast + leukemic cells $>$ 25-30%). Since the patient's initial bone marrow was populated entirely by lymphoblasts, it was not difficult to interpret this as a leukemoid reaction secondary to chemotherapy and marked granulocytopenia. The subsequent leucocytosis, appearance of immature myeloid cells in the peripheral blood, and the prompt return of bone marrow and peripheral blood findings to normal would also support this concept. A similar reaction in patients with acute myeloblastic leukemia would present greater difficulties in differentiating leukemic immature cells from actively regenerating normal myeloid cells. Even so, a recent report by Ellison *et al*[15] indicated that increased myeloblasts and promyelocytes following drug induced pancytopenia can be recognized as emerging young normal cells and be differentiated from reappearance of leukemic cells. Since the cells in lymphoblastic leukemia are more sensitive to cytotoxic drugs than the hemopoietic cell,[16] thus allowing destruction of leukemic cells without marked suppresion of the bone marrow's ability to regenerate, one would expect to see this reactive leukemoid reaction more frequently in acute lymphoblastic leukemia than in acute myeloblastic anemia. In either case, the recognition of this reaction would be important in the management of acute leukemias with repeated intensive drug therapy.

Several recent studies in animal models have indicated that experimentally induced neutropenia was associated with the demonstration of a humoral factor which caused an increased rate of flux from committed granulocytic stem cell compartments into myeloblast-promyelocyte compartment and increased rate of production of neutrophil precursors.[17–20] It is rea-

sonable to postulate a similar mechanism in humans.

SUMMARY

A 31-year-old farmer with acute lymphoblastic leukemia went into complete marrow remission following one course of cytosine arabinoside-vincristine-prednisone therapy.

With each successive course of the same treatment to maintain complete remission, he developed marked granulocytopenia followed by transient marked increases in blasts and promyelocytes in the bone marrow and leukemoid peripheral blood pictures. This response may be difficult to differentiate from marrow relapse and progression of the leukemic process under chemotherapy.

REFERENCES

The references noted in this article are available on request from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

BLANK CONFERENCE APRIL 12 AND 13

Seventeenth Annual Blank Hospital Pediatric Conference will occur April 12 and 13 at the Iowa Methodist School of Nursing, 1100 Pleasant Street, Des Moines. Sponsors are the Raymond Blank Hospital Guild, the Division of Maternal and Child Health of the State Department of Health and the Iowa Chapter, American Academy of Pediatrics.

Full registration is $40; one-day registration is $20. Fee is waived for interns and residents.

Topics to be considered include juvenile rheumatoid arthritis, immunologic investigation of the child with recurrent infection, newborn hematology, neurologic diagnosis by inspection, hemolytic disorders of childhood, minimal cerebral dysfunction, lung diseases caused by immunologic injury and cystic fibrosis.

Speakers include Joseph Bellanti, M.D., professor of pediatrics and microbiology, Georgetown University; Alvin Zipursky, M.D., professor of pediatrics, McMasters University, Hamilton, Ontario, Canada; Arnold P. Gold, M.D., associate professor of neurology and pediatrics, Columbia University; and Robert Gauchat, M.D., professor of pediatrics, U. of I.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

AUTOMOBILE SAFETY

Each weekend leaves behind a trail of blood, torn flesh, death and piles of mangled steel and plastic. Also, there remain tears of grief, broken families, and many others permanently crippled or disfigured. Automobile accidents in Iowa accounted for 871 deaths in 1972, to say nothing of the millions of dollars in damaged property and medical and hospital expenses, as well as lost income. For example, in 1971 Iowa drunk-driving accidents cost $5.5 million; accidents due to failure to yield right-of-way cost $9.4 million.

The medical profession has been concerned about automobile safety for many years. Committees and individuals have worked long and hard in the effort to decrease carnage on the highways. Furthermore, significant advances have been made in providing more immediate attention to those injured. Cooperation with safety and traffic officials has been extensive. Automobiles have more and more safety innovations each year—padded dashboards and sun-visors, safety belts, collapsible steering columns, "better" construction; forthcoming are optional computer ignition switches that require a certain sequence of number input, this to deter an inebriated individual from operating the vehicle.

Perhaps these measures are not enough. What can and will be done about all the unsafe automobiles on the roadways? What additional controls are needed over incompetent drivers? Why are there no strict controls over the many modified automobiles now speeding on the streets and highways? I refer to automobiles with the rear ends blocked up in such a way as to expose the fuel tank, "slick" tires with no tread, "muscle" cars with excessive speed potential, automobiles with worn shock absorbers, as well as just plain totally worn-out unsafe vehicles. It would appear sensible to consider the need for revised laws regulating the condition of automobiles. True, in Iowa inspection is required prior to the sale of an automobile, but once the automobile is in possession of the new owner the modifications may be repeated or the deficiencies forgotten. Many of the popular automobile modifications are very hazardous. Front spring stiffeners promote dangerous handling. Modified wheels often cannot withstand the strain of cornering as well as centrifugal forces. Oversize tires can impinge on the structure of the vehicle during certain maneuvers causing a one-wheel-brake effect. Interior add-ons can be hazardous to the occupants of the automobile when involved in an accident that otherwise might not have been so tragic.

What a joy it would be if there were provisions to prevent a drunken individual from operating a motor vehicle. Why is it national statistics show drinking drivers are involved in more than 50 per cent of auto crashes involving fatalities, while in Iowa this figure is 35 per cent? There are just as many drinkers in Iowa, and they drive cars. Are they not reported? Are they not apprehended? The Iowa accident report requires a statement from each driver whether drinking alcohol preceded the

accident. Is that as far as it goes in some communities? If drinking is involved more reports are required, testimony in court is mandatory, and the time involved may render no added compensation for those involved. Annually 20,000 people die in crashes involving drinking drivers; 2,000,000 people suffer disabling injuries.

Education and strict enforcement of existing laws seems the only answer.—M.E.A.

INFORMED CONSENT

The interpretation of informed consent is an issue which concerns the physician in a manner that is threatening to an increasing degree. The courts are ruling that the patient has the right of self-determination for non-emergency medical care. The January 1973 issue of THE PHYSICIAN'S LEGAL BRIEF contains a provocative discussion by Don Harper Mills, M.D., J.D.,* on this subject. The summary of this presentation deserves repeating.

These are the "do's" and "don'ts" on informed consent as presented by Dr. Mills:

DO'S

1. Disclose the identity of the proposed procedure.
2. Disclose the identity of the chief surgeon when he is other than the attending physician.
3. Disclose the risk of death or serious harm when applicable.
4. Disclose peculiar risks associated with a specific procedure.
5. Disclose risks to a greater extent when the proposed procedure is: (a) experimental, (b) new or novel, (c) ultrahazardous, (d) capable of altering sexual capacity or fertility, and (e) purely cosmetic in purpose.
6. Disclose the intent to perform procedures incidental to the principal procedure.

DON'TS

1. Do not inform a patient that the proposed procedure is simple.
2. Do not inform a patient that no complication will occur.
3. Do not expect to obtain an informed consent by merely answering the patient's questions.
4. Do not expect nurses or paramedical personnel to make disclosures required for an informed consent.
5. Do not expect the consent to justify the lack of adequate indications for a procedure, unless the patient is so informed.

Specific, voluntary disclosures to patients may not be necessary when the risk (s) should already be known by lay persons of average sophistication; or the risk (s) are already known to the patient; or the patient specifically requests not to be informed of risks.—M.E.A.

* Mills, Don Harper, Issue of informed consent looms as major problem for physicians. THE PHYSICIAN'S LEGAL BRIEF, Vol. 5, No. 2, Jan. 1973, Schering Corp., Bloomfield, N. J.

1973 HOUSE OF DELEGATES

Following an approved and revised format, the 1973 Iowa Medical Society House of Delegates will convene its Annual Meeting at 2 p.m. on Saturday, April 28, in the Grand Ballroom of the Fort Des Moines Hotel in Des Moines.

Events Sunday, April 29, include open hearings of the Reference Committees beginning at 8:30 a.m. Opportunity will be allowed for the preparation of Reference Committee Reports during the afternoon. The House of Delegates' Banquet is planned Sunday evening.

It is hoped the second and concluding session of the House of Delegates will begin at 8:30 a.m., Monday, April 30.

Now in the final stages of preparation is the Handbook for the House of Delegates which contains committee reports and resolutions received up to press time. County medical societies may continue to submit resolutons for consideration by the House; early filing of such resolutions allows an opportunity for advance discussion.

State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

A GOOD PRESCRIPTION FOR NURSING HOME RESIDENTS

Rx: Bake cookies; participate in group exercises, grow tomatoes, join current events groups, P.R.N.

This may not be a normal prescription but it is often the proper medicine for the nursing home resident. Duane Schultz supports the proposition that man needs constantly varying forms of stimulation to function adaptively in his environment.* Long-term illness can remove a person from the everyday world where stimulation and normal activity are taken for granted. When an individual enters a nursing home, it is likely that only his basic physical needs will be cared for unless there is a definite plan for providing additional stimulation. *It is the purpose of the activity program to stimulate and challenge the individual, to make him feel worthwhile, and to create as near to a normal environment as is possible.* This personalized environment may include baking cookies for an open house or helping another resident to the dining room. It depends on the interests, needs, and personal life style of each resident.

The Chronic Illness and Aging Division of Family Health Service is playing a vital role in improving the activity programs of long-term care facilities in the state. A 36 hour orientation session has been designed by the occupational therapist and recreation therapist to introduce basic aspects of an activity program to activity directors. The two therapists have recruited and briefed teachers to instruct these sessions. During the 18 months the course has been offered in seven locations through the Community College system, including Des Moines, Ottumwa, Dubuque, Iowa City, Emmetsburg, Sioux City and Oelwein. A total of 114 individuals representing approximately 100 facilities have attended these orientation sessions.

The orientation session will be offered this spring in Boone through the Des Moines Area Community College, in Emmetsburg through the Iowa Lakes Community College, in Council Bluffs through Iowa Western Community College, and in Mason City through North Iowa Area Community College. New Health Department regulations make activity programs mandatory, and this increases the need for the orientation programs which are being offered.

In addition to the orientation sessions, the therapists have assisted in the organization of eight activity directors associations. These, along with the three associations already in existence, encompass all 99 counties. The main objective here is to upgrade the activity programs through continuing education of the activity directors.

The therapists also write and send THE ACTIVITY BULLETIN to all nursing and custodial homes and regional public health nursing offices in the state every two months.

You and your patient who is in or considering entering a nursing home have a right to expect that the home will offer activities that will interest and stimulate him. Whether the home offers a well-rounded activity program

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This summary was prepared by Carol Meindl, O.T.R., an occupational therapy consultant with The Chronic Illness and Aging Division of the Iowa State Department of Health.

* Schultz, Duane, SENSORY RESTRICTION (New York: Academic Press, 1965) pp. 1-57.

should be a major criterion for selecting a nursing home, and once in the home, the individual should be encouraged to participate. It was Ralph Waldo Emerson who said "Within I do not find wrinkles and used heart, but unspent youth." A positive attitude toward the capacities of the elderly will yield positive results.

Morbidity Report for January, 1973

Diseases	Jan. 1973	1973 to Date	1972 to Date	Most January Cases Reported From These Counties
Brucellosis	1	1	3	Woodbury
Chickenpox	1949	1949	1120	Des Moines, Linn
Conjunctivitis	53	53	38	Muscatine, Scott
German measles	39	39	32	Adair, Osceola
Gastrointestinal viral infection	1397	1397	936	Scattered
Hepatitis, infectious	20	20	22	Black Hawk, Polk
serum	3	3	1	Cerro Gordo, Polk, Union
Impetigo	30	30	54	Woodbury
Infectious mononucleosis	59	59	64	Johnson, Linn, Scott
Influenza-like illness	1213	1213		Scattered
Influenza-lab confirmed	16	16	4	Johnson
Measles	53	53	86	Cerro Gordo, Linn, Muscatine
Meningitis viral	1	1	0	Dallas
aseptic	1	1	0	Polk
associated with mumps	1	1	0	Warren
meningococcal	3	3	0	Benton, Clayton, Polk
Meningo-encephalitis	2	2	0	Johnson
Mumps	449	449	1166	Jackson, Warren
Pediculosis	17	17	0	
Pneumonia	149	149	113	Scott
Rabies in Animals	24	24	16	Scattered
Rheumatic fever	2	2	5	Jackson, Palo Alto
Ringworm, body	10	10	16	Scattered
Salmonellosis	14	14	7	Scattered
Shigellosis	39	39	30	Linn, Polk
Streptococcal infections	505	505	713	Johnson
Tuberculosis, active	10	10	12	Scattered
Venereal Disease syphilis	20	20	41	Scattered
gonorrhea	463	463	494	Scattered
Vincent's angina	1	1	0	Wright
Whooping cough	2	2	1	Muscatine, Scott



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Doctor's Business

by LARRY E. LEAVERTON

PROFESSIONAL CORPORATIONS INCREASINGLY POPULAR

Since the Iowa law was passed in 1970 permitting professionals to incorporate their practices, a significant number of physicians in groups and solo practice have done so. Others are either in the process or considering the move.

The doctor as a corporate employee is able to defer income to a retirement plan, something other corporation executives have been able to do since the 1930's. Contributions to the Plan are deductible to the corporation but are not included in the individual's income until he starts drawing his accumulation. Other benefits are in insurance, disability and reimbursement of medical expenses to employees of the corporation.

We have noticed that physicians practicing within the Professional Corporation framework have become more aware of their finances. The more orderly payment of taxes, for example, has eased budgeting problems. The supervision of funds invested has been improved. Where their retirement funds and those of their employees are at stake they are less apt to invest in highly speculative ventures which have often resulted in losses. The forced savings has assisted the doctor who has consistently overspent his income figuring "next year" he will accumulate investment and retirement funds. The medical office is able to compete with other businesses and professions through fringe benefit packages. While still subject to Wage Stabilization regulations, substantial benefits above previous levels are possible. In group practice a corporation is subject to statutes which require a formal organization with control, authority and responsibility sharply defined. This may be more effective than in partnerships where authority is often divided, spread too broadly, or non-existent.

Existing and future professional corporations should look, act, and function as such. This includes use of the letters P.C. in all correspondence, signs, announcements, stationery, statements and records, telephone directories, leases and all other contracts, and bank accounts. Avoid all self dealing such as payment of personal items with corporate funds or loans to stockholders. Be certain to comply with regulations such as the Wage Stabilization Program, conduct proper corporate meetings with appropriate minutes and written resolutions covering salaries, employment agreements, dividends, etc. Do not be so aggressive in seeking tax benefits that this overshadows the basic business purpose of the corporation. Continuing good legal and management counsel should be retained.

New legislation affecting Professional Corporations and Self Employed Retirement Plans is still probable.

Substantial benefits can be derived in many instances from incorporation. However, it is not necessarily right for every practice. Income must be sufficient to provide investment funds. The Professional Corporation does not create dollars except through some tax savings from deferred tax on funds put into the plan. If a doctor has debts from educational loans, notes on equipment, or mortgages on a medical

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

building or residence, or spends all of his income for personal living, it is unlikely he will have funds to invest after incorporating. Discipline in personal spending is required to maintain a standard of living and meet financial obligations, since the funds diverted to the retirement plan will not be available for personal use.

Some doctors do not like the regimentation involved of employment under a corporate structure. The corporate way is more formal and time consuming. Stockholders' meetings, board meetings with formal resolutions and minutes are necessary. The unincorporated doctor or partnership can still compete for employees through liberal salaries and deductible fringe benefits and through the more restricted and limited but still effective Self Employed Retirement Plan.

A professional corporation can offer some substantial and attractive tax saving advantages. As with all matters affecting taxes, investment and financial planning, a doctor considering incorporating should be certain he gets competent legal and financial advice, beginning with a feasibility study of potential benefits.

IOWA MEDICAL MISCELLANY

(Continued from page 97)

CONTINUING EDUCATION . . . Survey of 150 randomly-selected IMS members is in process to determine activities, needs and desires in continuing medical education. Project is joint effort of IMS Committee on Medical Education and Hospitals and U. of I. Office of Continuing Medical Education.

MECO PROJECT . . . For third year IMS has endorsed MECO project of SAMA which puts freshman medical students into community hospitals during vacation periods to broaden their medical perspective. Society is urging local support of program.

RUBEOLA . . . Following recommendation of IMS Committee on Maternal and Child Health has been approved: IMS notes appearance of rubeola in school-centered outbreaks. Because disease causes discomfort and carries risk of acute and chronic complications, reasonable attempts should be made to interrupt its transmission. Attention is called to "Rapid Response to Measles Program" of State Department of Health. Program is meant to assist county medical societies. IMS strongly recommends county societies avail themselves of this program to minimize rubeola morbidity.

MEMBERSHIP EFFORT . . . IMS Judicial Council will conduct special membership campaign in 1973 to restore to membership those few physicians who've dropped from Society ranks in recent years.

CO-SPONSOR . . . IMS will co-sponsor six workshops on medical care evaluation with Iowa Hospital Association, Blue Cross, IRMP, State Department of Social Services and U. of I. College of Medicine. Workshops will be in Waterloo (3/3), Des Moines (3/14), Mason City (3/15), Sioux City (5/2), Council Bluffs (5/3) and Amana (5/26-27).

PREFER BLOOD TEST . . . IMS Executive Council has instructed Legislative Committee to support blood test as preferred method of determining blood alcohol level in drivers arrested on OMVI charges. Breath test has been noted as acceptable with proper quality control.

LICENSURE BOARDS . . . General Assembly consideration of "consumer" representation on professional and occupational licensing boards is expected. Such proposal has come from interim study committee. Board of Medical Examiners would be required to include two lay members under measure being considered. IMS has opposed the change.

DRUGS . . . IMS is filing letter with Bureau of Narcotics and Dangerous Drugs (1) opposing proposed regulation to transfer "exempt narcotics" from Schedule V (prescription not needed) to Schedule III (prescription required), and (2) opposing BNDD proposal to transfer nine barbiturates from Schedule III (non-narcotic drugs) to Schedule II (prescription required).

IN THE PUBLIC INTEREST



The consideration of health maintenance organizations has spanned many months. During this period the Iowa Medical Society has strongly advocated the contracting approach to reimbursing physicians who provide services to HMO enrollees. The following discussion summarizes why the Society has taken this stand. We recognize the statement has already had the benefit of broad circulation. We offer it as the March In the Public Interest feature for the historical record.

The Iowa House of Representatives and Senate have now passed HMO bills which preserve the "corporate practice rule" and include HMOs in with several previous exemptions to this rule. By this compromise action the "corporate practice rule" is retained and the legislators' desire to have both contract and salary options is fulfilled. Time will have to reflect the wisdom of the final legislative action which is taken.

By KENNETH E. LISTER, M.D.
PRESIDENT, IOWA MEDICAL SOCIETY

A LEGISLATIVE proposal to authorize the operation of health maintenance organizations (HMOs) is one of the important measures before the 1973 Iowa General Assembly.

The HMO is an organized health care framework which accepts the responsibility to arrange and assure the delivery of an agreed-upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a geographic area, and it is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

Recent press reports have implied the Iowa Medical Society wishes to cripple this legislation to authorize HMOs in Iowa.

For the past two years, the Iowa Medical Society has consistently supported HMO enabling legislation. The Society, whose membership includes approximately 2,400 Iowa physicians, is a supporter of the present bills (S.F. 25 and H.F. 29) which were developed by a conscientious legislative study committee. The current proposal contains many improvements over the HMO bills filed in previous years.

LONG DELIBERATION

In this long and worthwhile deliberative process, however, the Medical Society has consistently urged that HMOs not be authorized to hire physicians as employes.

For the important reasons noted here, the Iowa Medical Society is asking the General Assembly to amend the bill under consideration so HMOs will be free to contract with physicians, or groups of physicians, for their services but will not be given the presently unlawful privilege of hiring them as employes.

ENTER HMO STATEMENT FOR THE RECORD

Is this a crippling amendment? It is the Society's conviction that our amendment will enhance the prospects for HMOs—its rejection will diminish those prospects.

What are the facts?

• **It will take a lot of time, money and effort** to launch an HMO even under the best of conditions.

• **Especially in the beginning, it will be** necessary to involve practicing Iowa physicians on a full- or part-time basis, and in a variety of contractual arrangements, to provide broad medical services to HMO enrollees.

• **The Iowa Medical Society is not opposed** to—nor does Iowa law prohibit—the employment of physicians on salary by corporations or lay groups where the physician is hired for purposes other than those of treating patients. Nor is it illegal or improper for physicians to be "employes" of other physicians.

• **Rightly or wrongly—and the Society** thinks rightly—physicians have strong feelings about their freedom to practice medicine without the threat of lay interference and control, and they regard the present Iowa law (the so-called "corporate practice rule") as a fundamental safeguard in affording protection against a violation of this freedom.

• **Even though the present HMO bill makes** it "optional" for physicians to be either "employes" or "independent contractors," it would constitute a beginning breakdown of a law and a concept which is as meaningful to physicians as is "academic freedom" to educators, "freedom of the press" to journalists, or "religious freedom" to clergymen and others.

• **It is the rare exception for HMOs to hire** physicians on salary. The overwhelming practice is to contract with them. In no case is it essential to the success of an HMO that it be given the presently-illegal power to engage the services of practicing physicians as "employes."

• **This is a matter of "principle" not** "money," as the physician's compensation as an "independent contractor" need not be greater than his compensation as an "employe."

What conclusions may be drawn from these facts?

As a physician, I know that most of my colleagues in the Iowa Medical Society would appreciate action by the legislators to eliminate from the HMO bill the proposed authority to hire physicians on salary. Such action would show an understanding of and consideration for the desire of physicians to practice good medicine free from the threat of lay interference and control. In return, the optimum favorable climate for physician participation in and support of HMOs would be established. This would be especially important in the first years of the HMO experiment.

BROAD DISAPPOINTMENT

Widespread disappointment and anxiety will result among physicians if this proposed breach in the "corporate practice rule" becomes law—particularly when they recognize it is not at all essential to the successful operation of HMOs.

Rash action by the Iowa Medical Society is not predicted under any circumstances, but resentment on the part of many physicians is unavoidable and predictable.

This much is readily apparent—both the sponsors of the HMO bill and the Iowa Medical Society want HMOs to have a real chance of success. There is an honest difference of opinion whether the "corporate practice rule" is a "stumbling block" or a "stepping stone" to this goal. This vital question deserves open-minded debate, dialogue between legislators and individual physicians and others, and a wise and enlightened policy and political decision by our lawmakers.

The Iowa Medical Society urges the legislators to trust their physician-constituents in this political matter with the same faith they would have in consulting them professionally. If our position proves wrong in actual practice, it can easily be rectified by a subsequent General Assembly. If we are right but nonetheless "outvoted," the damage will have been done. It will make no difference whether it was a "stumbling block" or a "stepping stone" —by then it will surely be a "millstone" around the necks of all.

Medical Assistants

by TENORA MEYER, CMA

WONDERFUL WORLD, BEAUTIFUL PEOPLE— A LOOK AT SOCIETY TODAY, IN SICKNESS AND IN HEALTH

Seventeenth annual convention of the American Association of Medical Assistants, State of Iowa, Inc., will be May 4-6 at the downtown Holiday Inn in Des Moines. Convention theme (listed above) promises a look at today's society in relation to contemporary medical problems. Up-to-date information on becoming a certified medical assistant will be provided as part of a "fun-filled" weekend. Recently the AAMA constitution was revised to include membership for D.O. employees, thus employees of M.D.'s and D.O.'s are invited to the Iowa convention.

The 1973 convention chairman is Betty Ehlert; the convention co-chairman is Colleen Proffitt, and the publicity chairman is Diane Day Vanasco.

Any *non-member* wishing to attend the convention should register *not later than April 1.* You may use the form provided or a facsimile:

NON-MEMBERS ONLY—DETACH & RETURN

Registration for all non-members:
$20.00 (meals and educational sessions)
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Return this form and check (made payable to AAMA, Des Moines Chapter, Special Account) to: Nancy Greteman, Registration Chairman, c/o Orthopedic Associates, P.C., 1045 5th, Des Moines, Iowa 50314.

PROGRAM

FRIDAY, MAY 4

4:00- 8:00	Registration
6:30- 8:00	Executive Council Meeting
6:30- 8:00	Dinner (Your Choice)
8:00- 9:00	Des Moines Chapter Welcoming Party
9:00-	Campaign—Open House

SATURDAY, MAY 5

7:30-12:00	Registration
7:30- 9:00	Continental Breakfast
8:00- 9:00	House of Delegates
9:30-10:00	General Assembly
10:00-11:45	Panel on Alcoholism Panel Members: Rev. Kermit Marsh, Earl Fitts, D.O., Gene Messenger
12:15- 1:30	Luncheon—Top of the Tower Style Show—compliments of Feldmans
1:30- 3:00	Program: Catherine Condon, M.D. "Kidney Dialysis"
4:00- 5:00	Registration
6:00- 7:00	Cocktail Hour
7:15-	Banquet

SUNDAY, MAY 6

8:30- 9:30	Continental Breakfast
9:00- 9:30	Post Convention Board Meeting
9:30-10:15	Program: John Kelley, M.D. "Government Role in Medicine"
10:15-11:00	AAMA Representative
11:30-12:15	Luncheon

About IOWA Physicians

Dr. J. E. Murtaugh, New Hampton, was elected chief of staff at recent meeting of Saint Joseph Community Hospital physicians. Other new Saint Joseph officers are **Dr. Dennis R. Olsen,** vice president; and **Dr. James C. Carr,** secretary. . . . **Dr. Rogelio T. Alojado,** Manila, Philippines, has joined the Beaverdale Clinic in Des Moines. Dr. Alojado is a 1967 medical graduate of University of Santo Tomas in Manila and interned at Santo Tomas University and Mercy Hospital in Des Moines. . . . The report of American Academy of Opthalmology and Otolaryngology Subcommittee on Equilibrium and Its Measurement, headed by **Dr. Brian F. McCabe,** professor and head of Department of Otolaryngology at U. of I. College of Medicine, was published in November-December issue of TRANSACTIONS, official journal of AAOO. . . .

Dr. John W. Castell, Fairfield, retired from active practice December 31. A U. of I. medical graduate, Dr. Castell interned in Binghampton, New York, and began his practice in Fairfield, his hometown, in 1936. Dr. Castell hopes to serve voluntarily either with the Hospital Ship HOPE or Project CONCERN. . . . **Dr. Joseph A. Heaney,** formerly of Ames, has relocated his office for the practice of psychiatry in Des Moines. Dr. Heaney is continuing his Ames practice on a part time basis but will eventually phase it out and be at Des Moines Medical Center and Iowa Lutheran Hospital full time. Dr. Heaney had practiced in Ames since 1967. . . . **Dr. Robert A. Huber,** Charter Oak, has been elected chairman of the Crawford County Memorial Hospital medical staff. Other new officers are—**Dr. R. L. Bendixen,** Denison, vice chairman, and **Dr. M. U. Broers,** Schleswig, secretary-treasurer. These new staff officers have also been elected to similar positions in the Crawford County Medical Society. . . . **Dr. Hubert Peterson,** Des Moines pathologist, has been named Polk County medical examiner by Board of Supervisors. . . .

Dr. Michael Crane will join **Dr. Jerald D. King** in Nevada April 1. Dr. Crane received M.D. degree at U. of I. College of Medicine in 1970 and interned at Broadlawns Hospital in Des Moines. He is completing military service at the Memphis Naval Air Station. . . . At recent meeting of local chamber of commerce, **Dr. R. J. Coble,** was presented Lake Park's "Honorary Citizen Award" in recognition of his community service. Dr. Coble was also recently elected president of Silver Lake Country Club. . . . **Dr. Donovan F. Ward,** Dubuque, has been reappointed to American Medical Association's Council on Legislation. The council is a standing AMA committee which reviews proposed federal legislation and recommends AMA policy changes to accomplish legislative goals. . . . **Dr. Leonard Lamberty,** Decorah, has been appointed to Winneshiek County Commission on Hospitalization, the three-member board which considers commitment matters.

Dr. John Rhodes, Jr., Pocahontas, is new chief of staff at Pocahontas Community Hospital; **Dr. John Rhodes, Sr.,** is vice chief; and **Dr. James Gannon,** Laurens, secretary. . . . **Dr. John C. MacQueen,** associate dean, U. of I. College of Medicine, spoke at March 1 meeting of Chickasaw County Public Affairs Discussion group. His topic was "Designing Rural Health Care System." . . . **Dr. Chester Janas,** psychiatric

resident at Independence Mental Health Institute, began private practice of medicine in Jesup in February. Dr. Janas received M.D. degree from University of Illinois School of Medicine and interned at St. Luke's Hospital in Cedar Rapids. From 1969 to 1971, Dr. Janas served in Army Medical Corps. He began his MHI residency in psychiatry in 1971. Dr. Janas has leased former office building of **Dr. R. L. Knipfer,** long-time Jesup physician now residing in Van Nuys, California. . . . Area 14 Health Planning Council has re-elected **Dr. J. C. Nolan,** Corning, its president. . . . **Dr. Kenneth Lemon,** Oskaloosa, spoke at recent meeting of Oskaloosa Women's Club. He discussed venereal disease.

Dr. L. A. George, Remsen physician for 25 years, was honored by local citizens at January open house. Dr. George is a 1943 graduate of U. of I. College of Medicine. He interned and had a surgical residency in Flint, Michigan. He's served on Remsen town council, as a director of Farmers Savings Bank and trustee of utility board. He was Remsen's 1972 citizen of the year. . . . January program of Wright County Medical Society was presented by **Dr. J. H. Brinkman,** Mason City endocrinologist and director of Iowa Foundation for Medical Care. He discussed HR-1 and PSRO. . . . **Dr. Harold A. Van Hofwegen** has joined **Drs. Clare C. Jones, George F. Fieselmann** and **J. E. Kelly** in Spencer. Dr. Van Hofwegen formerly practiced in Newton and is a 1961 U. of I. medical graduate. . . . **Dr. Harry A. Mahannah** is new president of Davis County Medical Society. Other officers: **Dr. H. J. Gilfillan,** vice president; **Dr. John R. Scheibe,** secretary-treasurer; **Dr. Henry M. Perry,** delegate; and **Dr. Philip W. Caster,** alternate. All are Bloomfield physicians.

Dr. Harold Sauer, Marshalltown, has been reappointed to two-year term on Marshall County Hospitalization Commission. . . . Following Mason City physicians were recently elected to head 1973 Mercy Hospital medical staff—**Dr. Benjamin Broghammer,** president; **Dr. William Rence,** vice president; and **Dr. Samuel Porter,** secretary-treasurer. . . . **Dr. Charles deProsse,** professor of obstetrics and gynecology at U. of I. College of Medicine, was speaker at recent parent health education program in Tipton. Program on sex, contraceptives, abortion and venereal disease was sponsored by Tipton Board of Education. . . . **Dr. Beryl Michaelson** has discontinued her medical practice in Dakota City. A 1945 U. of I. medical graduate, Dr. Michaelson has practiced in Dakota City since 1955. She plans to travel and spend leisure time at a home in Lake Shamineau, Minnesota. Further medical practice plans are indefinite.

Dr. Clyde Deal, West Union, is new chief of staff at Sumner Community Memorial Hospital; **Dr. Norman Elmer,** Sumner, is vice chairman; and **Dr. Regis Weland,** Cedar Rapids, is secretary-treasurer. . . . Polk County Medical Society has installed **Dr. John Hess, Jr.,** as president. New officers are: **Dr. Marvin H. Dubansky,** president-elect; **Dr. Donald F. McBride,** trustee for five-year term; **Dr. Donald C. Young,** councilor for three-year term; and **Dr. Lester Beachy,** secretary-treasurer. All officers are Des Moines physicians. . . . **Dr. Donald L. Cross,** Boone, has retired after 39 years of medical practice. Dr. Cross is 1934 medical graduate of University of Louisville. He interned at Presbyterian Hospital in Denver, Colorado, and took a residency in obstetrics and gynecology at Doctors' Hospital in New York City and Syracuse (N.Y.) Medical School. Dr. Cross came to Boone in 1946 after military service. He plans to continue living in Boone.

Dr. A. L. Murphey, Fredericksburg physician for 37 years, retired from active practice January 1. Dr. Murphey received M.D. degree at U. of I. College of Medicine and interned at Prairie View Hospital in Minneapolis. He is charter member of Lions Club, past school board member and board member of American Cancer Society, Iowa Chapter. Dr. Murphey was Fredericksburg mayor for 12 years. . . . **Dr. Salvador R. Borja** has been named pathology laboratory director at Mercy Hospital in Clinton. Dr. Borja received M.D. degree at Santo Tomas in Manila, Philippines. He served residency in pathology at Monmouth Medical Center in Long Branch, New Jersey; residency in clinical pathology at Missouri Baptist Hospital in St. Louis, and also participated in medical radioisotope course at Oak Ridge, Tenn. Dr. Borja is fellow of College of

American Pathologists and American Society of Clinical Pathologists. . . . The following Lake City physicians—**Drs. Dale Christensen, Paul Ferguson, Cesar Cardenas** and **Charles Comstoek** participated in recent Lake City Smokers Clinic sponsored by Stewart Memorial Hospital and McCrary Rost Clinic. . . . **Dr. E. M. Eneboe,** Hawarden, was presented "Man of the Year Award" for many years of service to Hawarden community at annual Chamber of Commerce banquet. . . . **Dr. David Wright,** Decorah, was recently reelected president of Winneshiek County Hospital medical staff. Other officers are **Dr. Garfield Miller,** Calmar, vice president; and **Dr. Conrad Larsen,** Decorah, secretary-treasurer.

Dr. William Owen, St. Ansgar, was featured in December 23 issue of NATIONAL OBSERVER on his travel to and service in Vietnam. Dr. Owen is completing third tour of duty in South Vietnam. . . . **Dr. S. P. Gutierrez,** Waukon, was recently named diplomate of American Board of Surgery. . . . **Dr. E. A. Kjenaas,** director of psychiatric training and research at Cherokee Mental Health Institute, was main speaker at January program on "Aging in American Society" for Buena Vista College students in Storm Lake. . . . At recent meeting of local Lions Club, **Dr. L. H. Boeke,** West Union physician, explained proposed intensive care units for community's hospital and outlined briefly changes in Medicare laws. . . . **Dr. Dennis Olsen,** New Hampton, discussed health needs and concerns of medical profession at recent meeting of Chickasaw County Health Planning Assembly. . . . **Dr. James T. Worrell,** Keosauqua, is new member of Van Buren County Health Care Planning Council.

Coverage of Iowa General Assembly under program of Iowa Academy of Family Practice has involved among others: **Dr. C. W. Beckman,** Kalona; **Dr. Harold Moessner,** Amana; **Dr. Donald J. Ottilie,** Oelwein; **Dr. Keith Mills,** Lone Tree; and **Dr. Larry Boeke,** West Union. . . . **Dr. F. Waly,** Humboldt, has moved from Doctor's Park to former downtown offices of **Drs. J. H. Coddington** and **M. L. Northup.** Dr. Waly will supplement pediatrics practice with limited amount of general practice. . . . **Dr. William McAllister,** Independence, received plaque at recent meeting of board of directors of North Iowa Area Community College for his long service. First building on new NIACC campus has been named McAllister Hall in his honor. Dr. McAllister served on NIACC board of directors from 1966 until 1972. . . . **Dr. Annette Fitz,** associate professor of internal medicine at U. of I. College of Medicine, spoke at recent meeting of Wapello County Medical Society. Dr. Fitz' topic: "Work-up of Hypertensive Patient." . . . **Dr. David Rater,** Ottumwa internist, **Dr. Dwain Eckberg,** assistant professor of internal medicine at U. of I., and **Dr. Donald Doty,** assistant professor of surgery at U. of I., participated in recent cardiology session at St. Luke's Hospital in Cedar Rapids. Dr. Rater covered late complications of myocardial infarction, Dr. Eckberg discussed indications for coronary angiography and Dr. Doty described patients needing coronary artery surgery. Event was sponsored by Cedar Valley Heart Association.

Dr. A. Curtis Hass, director of the Margaret and Howard Hall Radiation Center in Cedar Rapids, discussed addition to Center at recent board meeting of Linn County Chapter of American Cancer Society. . . . **Dr. John MacQueen,** professor of pediatrics at U. of I. College of Medicine, spoke at recent annual meeting of Health Planning Council of North Central Iowa in Fort Dodge. He reviewed medical care and health services in Iowa. . . . **Clifford Rask,** M.D., is new chief of staff at Jackson County Public Hospital; **Sam Williams,** D.O., Vice Chief of Staff; and **Paul Gjerstad,** M.D., secretary-treasurer. **O. L. Frank,** M.D., retained his position as chief of staff emeritus. All are Maquoketa physicians. . . . **Dr. L. F. Parker,** of Des Moines, spoke at recent meeting of Hardin County Medical Society. . . . **Dr. Carl Lester,** an orthopedic surgeon, has joined **Dr. John Hughes** in Marshalltown. Dr. Lester received M.D. degree at University of Illinois. He interned at San Bernardino County Hospital in California and completed his residency at Hines VA Hospital in Chicago. Dr. Lester is certified by American Board of Orthopedic Surgery. . . . **Dr. R. J. Coble,** Lake Park, is chairman of the Dickinson County Heart Fund campaign. . . . **Dr. Kenneth E. Lister,** Ottumwa, president of Iowa Medical Society, was speaker at recent meeting of Black Hawk County Medical Society. Dr. Lister discussed

the Iowa Foundation for Medical Care. . . . **Dr. C. Robert Osborn,** Dexter, spoke at recent meeting of Dexter Woman's Club. He told of his trip to Honduras and Haiti.

These physicians have been elected 1973 medical staff officers of Grinnell General Hospital: **Dr. W. I. Evans,** chief of staff; **Dr. D. L. Ferguson,** vice chief; and **Dr. R. M. Carney,** secretary. . . . **Dr. Robert T. Guthrie** has joined **Drs. John L. Kestel, Clarence J. Ludwig** and **Gerald M. Vandervelde** in Waterloo radiology practice. Dr. Guthrie received M.D. degree at U. of I. College of Medicine in 1964 and interned at Los Angeles County General Hospital. He entered U. S. Naval Aerospace Institute and served as flight surgeon until December, 1967. Dr. Guthrie completed his radiology residency at University Hospitals in Iowa City and since January, 1970, has served on staff of Department of Radiology, Radiation Therapy Section, attaining rank of assistant professor.... **Dr. Robert J. Barry,** former Sioux City dermatologist, has relocated his practice in Cedar Rapids. Dr. Barry practiced in Sioux City from 1969 until December, 1972. . . . Guthrie County Hospital medical staff officers for 1973 are—**Dr. D. E. Taylor,** Stuart, chief of staff; **Dr. Herbert Neff,** Guthrie Center, vice president; and **J. L. Abramsohn,** D.O., Guthrie Center, secretary. . . . **Dr. David McCoy** has been elected president of Carroll County Medical Society; **Dr. Paul T. Cawley,** vice president; **Dr. Eleanor Roverud,** secretary-treasurer; **Dr. James McGill,** delegate; and **Dr. Homer Skinner,** alternate delegate. All are Carroll physicians. . . . **Dr. Gerald A. Brooks,** newly appointed medical director of Siouxland Mental Health Center, was special guest at reception in honor of his appointment to Siouxland position. Previously, Dr. Brooks was chief of children's unit at Cherokee Mental Health Institute, and also assistant medical director of Northwest Iowa Mental Health Center at Spencer. Dr. Brooks is a 1963 graduate of Tulane Medical School and interned at Huey P. Long Charity Hospital in New Orleans. He served his psychiatric residency at Cherokee and in 1970 became senior staff psychiatrist there.

Dr. Robert Melgaard, Dubuque, is new president of Area Residential Care, Inc., a private non-profit corporation serving needs of mentally retarded in Jackson, Delaware and Dubuque Counties.

DEATHS

Dr. C. F. Watts, 82, died December 31 at his home in Marengo. A 1917 graduate of University of Chicago and Rush Medical School, Dr. Watts retired last year. He had practiced medicine in Marengo since 1939 and in Iowa since 1918. He was president of the staff of Marengo Memorial Hospital until he retired and was active on the staffs of Cedar Rapids' two hospitals. Dr. Watts was named to Hall of Fame of Iowa Saddle Horse Association in 1970 as a result of his long interest in horses and his effort to bring better breeding to the state. He was a member of American College of Surgeons, past president of Iowa County Medical Society, life member of Iowa Medical Society and American Medical Association.

Dr. John D. McDaniel, 64, a former Marengo physician, died December 12 at Robert Lee, Texas. A 1938 graduate of U. of I. College of Medicine, Dr. McDaniel interned at St. Luke's Hospital in Cedar Rapids. He practiced medicine in Marengo from 1939 until 1946.

Dr. Morgan J. Foster, 75, a retired Cedar Rapids pediatrician, died January 12 at a Cedar Rapids hospital. A graduate of U. of I. College of Medicine, Dr. Foster interned at Children's Hospital in Iowa City and completed his pediatric residency at City Hospital in Cleveland, Ohio. He was a member of Iowa Medical Society, American Medical Association, American Academy of Pediatrics, past president of Iowa Pediatrics Society, Mercy and St. Luke's hospital staffs, and Linn County Medical Society.

Dr. John C. Teufel, 92, a Davenport physician for 68 years, died January 27 at Mercy Hospital. A 1904 graduate of U. of I. College of Medicine, Dr. Teufel began the practice of medicine at Buffalo in 1905, and moved to Davenport in 1924. A life member of the Iowa Medical Society and American Medical Association, Dr. Teufel was Davenport's oldest practicing physician.

Pathology Capsules

By W. S. PHETEPLACE, M.D.

QUALITY CONTROL— TIME TO SEE HOW YOUR LAB MEASURES UP

"The poorest of all laboratory work is that done in the private physician's office." This allegation was made in a statement before the Senate Judiciary Committee on Antitrust and Monopoly by the Director of the New York City Department of Health Bureau of Laboratories on February 7, 1967. Is it true? Several years before this challenge was made hundreds of larger independent and hospital laboratories had already undertaken the task of evaluating laboratory results and resolving any resulting problems. The result: good quality control reagents and procedural techniques to use with them are now available and readily applicable to the smaller laboratories of practicing physicians.

In January, 1972 legislation in California and Arizona made it mandatory for physicians' office laboratories to participate in proficiency testing. The implications are clear: soon physicians may be required to evaluate critically their laboratories and bring them up to standard if problems are found.

Recognizing the significance of this trend, the Iowa Association of Pathologists has developed a regional quality control program which has been adopted and implemented by a large proportion of the hospital and pathologist directed laboratories in the state. This program has received the endorsement of the Iowa Medical Society and Iowa Hospital Association as a program which merits consideration of all practicing physicians and hospitals.

If your office or clinic has a laboratory that performs any clinical chemistries, prothrombin times, partial thromboplastin times, or blood counts, you may want to take advantage of the Quality Control Program for 1973 organized by the Iowa Association of Pathologists. The program is designed to provide a relatively inexpensive daily control of precision and is being utilized by the majority of hospitals and pathology laboratories in the state. Monthly computer printouts are returned to each individual participant providing not only the statistical data for that participant, but also including material showing how the performance of the individual compares with all of the other participants. All participants are identified by a number only, so that confidentiality is preserved.

It is anticipated there may be sufficient interest to justify some regional seminars on quality control data analysis and problem solving for the non-pathologist physician laboratorians. The Iowa Medical Society and Iowa Association of Pathologists will co-sponsor such programs if you request them. These education programs will not be restricted to participants.

If you are interested call or write your local Scientific Products representative; or Donald C. Justinger, DADE Representative, 242 22nd Ave. So., South St. Paul, Minnesota 55075; or J. X. Tamisiea, M.D., Chairman, Quality Control Committee, 918 10th St., Milford, Iowa 51351.

This series of articles is provided by the Iowa Association of Pathologists. This explanation has been furnished by W. S. Pheteplace, M.D., who practices pathology in Davenport, Iowa.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page



It is with mixed feelings that I write this April page.

Firstly, there is some sense of relief that my year of service to organized medicine in Iowa is approaching conclusion.

Secondly, I will miss the activity very much. Next to the practice of medicine, I have had no other activity which is as stimulating and satisfying.

I would like to thank you the members of the IMS for the chance to have served as your President and also to thank the dedicated staff and members of the Board for their total assistance in accomplishing the task.

I know that the function of the Society will continue in increasing directions and amounts since this seems to be the rule of the day. You are fortunate to have this activity controlled and directed by such fine men as you will elect to office this month.

Sincerely,

K. E. Lister, MD.

K. E. Lister, President

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IOWA Medical Miscellany

1973 ANNUAL MEETING . . . 1973 Annual Meeting of the House will occur April 28 to 30 (Saturday to Monday) at Hotel Fort Des Moines. Revised format calls for sessions of full House Saturday and Monday. Reference Committee hearings will be Sunday. Sessions of the House are open to interested members. Eight resolutions from county societies are in hand at press-time and will be considered by the House along with any others received.

HANDBOOK MAILED . . . Society activities for 1972-73 are highlighted in the Delegates' HANDBOOK mailed in March to those IMS members who'll represent their county societies at forthcoming Annual Meeting.

NOMINATING ACTIVITIES . . . Nominating Committee March 25 selected Ralph L. Wicks, M.D., Boone, as single candidate for IMS President-elect. Dr. Wicks has served two years as chairman of the Society's Board of Trustees. Other candidates for office are included in an IMS News Bulletin which has been distributed. Election will occur at second session of the House of Delegates April 30.

IMS MEMBERSHIP . . . Efforts to spur IMS membership continue. Eighty-eight physicians have joined Society ranks for the first time since October. District councilors are contacting those physicians not now members to encourage their participation.

SEE LEGISLATORS . . . Three Society representatives traveled to Washington, D. C., March 10 and 11 to confer with members of Iowa's congressional delegation. Society President K. E. Lister, M.D., made the trip with Vice-President Erling Larson, Jr., M.D., Davenport, and J. H. Kelley, M.D., Des Moines, chairman of the Legislative Committee.

CHIROPRACTIC . . . Deep Society concern has been expressed over legislative proposal (H.F. 299) to alter the chiropractic practice act. Statement issued recently by IMS President Lister describes this attempt to extend the scope of chiropractic practice as "more subtle" than previous attempts and "accordingly more dangerous." In strongly opposing the measure, Dr. Lister calls *protection of the public* the real issue.

IOWA MEDICAL LIBRARY . . . Iowa physicians are reminded the State Medical Library has various services readily available. Loans of books, photocopies of periodical articles, and bibliography assistance are among services provided. Toll free telephone (800-362-2884) is available Monday through Friday to make requests.

HMO LEGISLATION . . . Awaiting final approval is an HMO measure acceptable to both the Iowa House and Senate. Agreement is being sought by the lawmakers on the two proposals passed in February.

MEDICAL EVALUATION CONFERENCES . . . Final three of six regional workshops on implementation of quality assurance programs in community hospitals will be in Sioux City (5/2), Council Bluffs (5/3), and Amana (5/26-27). IMS is one of several organizations cooperating in this project with Office of Continuing Medical Education at The University of Iowa.

CARDIAC CARE SYMPOSIUM . . . June 1 Emergency Cardiac Care Symposium for physicians, nurses and other allied health personnel in Iowa and surrounding states is to be sponsored by the Iowa Heart Association. Symposium will be in Des Moines at Johnny & Kay's Hyatt House.

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The Question Box



by JOHN H. SUNDERBRUCH, M.D.

Dr. Sunderbruch is president of the Iowa Foundation for Medical Care. His responses here constitute a brief Foundation status report.

What's new with the Foundation?

Of most recent import to the Foundation is the enactment of H.R. 1 with its Professional Standards Review Organization (PSRO) provisions. This amendment to the Social Security Act entrusts to physicians initial responsibility for proper utilization of institutional services. It says *only* a physician can judge the medical necessity of services ordered by another physician. Organizations of at least 300 physicians will function as PSROs and oversee utilization review activities of institutions within their assigned areas. The Iowa Foundation, with minor modifications in or additions to its corporate structure, is expected to meet PSRO requirements. Foundation officers believe PSRO requirements can best be fulfilled in Iowa through the Foundation.

How many members do you have at this time?

The Foundation now has 1,113 MD and 132 DO members. We are continually increasing our membership. Our recent presentations at county society and other physician meetings have helped boost our membership. We are anxious to tell the Foundation story to all physician listeners.

What programs is the Foundation now serving? What third parties are involved?

The Foundation has been doing peer review on fees since this task was transferred from the Society. The Foundation is doing fee reviews for Blue Shield and some of the major private insurers. It is anticipated most insurers will be working with the Foundation in the future.

Recently, the Foundation consummated an agreement with Blue Cross/Blue Shield which attempts to anticipate the PSRO regulations. It involves helping hospitals develop UR programs to meet PSRO requirements. It will entail forming utilization screening parameters to be used in the BC/BS claims processing system. Claims outside the parameters will receive additional review.

Is the Foundation performing up to expectations?

Our timetable called for third party working agreements by January 1. In this respect we have been delayed in initiating some planned review activities. We hope to have working arrangements with most third parties in the state very soon. We anticipate the Foundation will move rapidly in quality and cost review when these agreements are signed.

More than 150 cases have been handled by the Foundation since it assumed the Society's peer review responsibilities. We have been impressed with the work of our district peer review committees. The peer review system should be able to sustain the Foundation's future activities.

What about PSRO and the Foundation?

The Foundation cannot qualify as a PSRO under its Bylaws. Federal law says a PSRO must be a non-dues organization. The Foundation requires $10 in dues as a non-recurring payment at the time of joining. The IFMC expects to comply with the law by making the necessary alterations in its Articles and Bylaws. This will allow retention of the present corporate framework and also allow for PSRO participation.

WHO CARES FOR THE CHILDREN?

There is a chronic shortage of pediatricians and family practitioners in Iowa. It is not surprising then that medical care is not readily available to segments of the public; children, unable to be their own advocates, are often the most neglected. The medical community is often unaware of the existence of many of these children: entire families are outside any medical service. On occasion, for instance, immunization clinics have attracted children whose existence and whose numbers have amazed local doctors. Obviously these are children not receiving medical care.

Some communities have sought a solution by creating child health conferences intended to serve chiefly medically indigent children (though this does not have to be the case). This enables people other than physicians to serve the children and thus cares for more patients more completely per unit of time than may be possible in other settings.

A child health conference is described here in general terms taken from suggested guidelines written by the Division of Maternal and Child Health.

THE CHILD HEALTH CONFERENCE

The Conference

The purpose of a child health conference is to provide continuing health supervision so children will not receive only crisis medical care. All parents need guidance in child care to promote healthy growth and development and to reduce the incidence of illness. The conference provides health supervision of children from infancy to school age. It refers for treatment children who are ill.

The principal services offered to families with small children are:

1. Health appraisal through history and physical examination.
2. Immunizations.
3. Discussion with parent(s) on all aspects of the child's health including child rearing practices and anticipatory guidance.
4. Guidance in nutritional needs of the family, especially of the young child.
5. Referral to outside agencies or consultants as needed, including home visits by a public health nurse as needed.

The area-wide health planning council can be of assistance in surveying the need for a child health conference. Because a conference is anticipated to serve chiefly children whose families are unable to purchase medical care (though not these children exclusively), various agencies such as the county medical society and the county social service department must be consulted during the planning stages. A medical advisory board develops policies for health care of the children.

The Conference Center

The conference center must be conveniently located for families expected to use it. A neighborhood center facility may be a good location. A hospital is ideal because equipment and laboratory facilities are readily available. There must be space for examinations, and some area must be provided for private interviews.

The Conference Team

The conference team is usually composed of one physician, two or more nurses and one or more assistants. Because physicians may not always be available, nurses are assuming

This discussion has been prepared by Elizabeth Procter, M.D. Dr. Procter is Director, Maternal and Child Health Division, State Department of Health.

an expanded role. The medical advisory board will provide a great amount of guidance in the operation of the child health conference in which a physician is not present continuously.

1. *The physician.* The physician is medical director of the clinic and is responsible for maintenance of good quality service by the child health conference staff. With the medical advisory board, he is responsible for general and specific policies relating to such procedures as infant feeding schedules, administration of vitamins, scheduling of immunizations and other similar items. He performs a periodic health appraisal of each child at intervals determined or suggested by the advisory board. He leads staff conferences with the child health conference team.

2. *The conference manager—(nurse-in-charge).* Is the coordinator between the family and the physician and is responsible for general management of the conference. The *conference nurse* counsels with the parent about health problems and child rearing practices, and provides anticipatory guidance. She is responsible for administering or supervising screening tests and administers immunizations according to the schedule. She shares with the physician or pediatric nurse practitioner in counseling the parent when the child is seen by him. The nurse may have knowledge and understanding of home conditions that may affect recommendations made by the examiner. The nurse makes home visits as needed.

3. *The pediatric nurse practitioner* (when available) is responsible for the physical examination of children and performs the Denver Developmental Screening Test. She counsels parents regarding the care of such minor illnesses as respiratory infection, diarrhea, diaper rash, and also diet, safety and child rearing practices. She refers families to proper agencies when social and family problems exist and for nursing followup as needs arise. She also provides inservice education for the team.

4. *Volunteers and/or health aides and/or clerks.* Volunteers can be very valuable and effective but the use of volunteers requires careful planning and selection. They should have a planned training program before beginning work in a conference.

5. *Consultant personnel* such as social workers and nutritionists assist parents with special problems.

A Conference Tool

An important focus of the conference along with evaluation of physical status is assessment of development. Developmental abnormalities can be detected only if they are looked for and suspected and tested for. Early detection allows for early diagnosis and treatment with maximum hope of benefit.

A screening test is available for use by trained non-professionals. The Denver Developmental Screening Test Manual states: "The Denver Developmental Screening Test (DDST) was designed and standardized to meet the need of having a simple, useful tool to aid in the early discovery of children with developmental problems. The test is designed for use by people who have not had special training in psychological testing and is easy to give and score . . . a child is tested on only twenty or so simple tasks or items."

The test may be administered by lay people or by nurses who have had some training (a few days) in administering it and recording the results. It is a *screening* test, intended to indicate the need for further diagnostic tests. The DDST is used in existing clinics, and the screeners are enthusiastic about its value.

Early and Periodic Screening for Diagnosis and Treatment

Title XIX of the Social Security Act requires early and periodic screening for diagnosis and treatment. The Medical Assistance Handbook for Physicians, distributed by the State of Iowa, Department of Social Services, on page 4b says:

Early and Periodic Screening, Diagnosis and Treatment of Children Under Age Six

The Federal Department of Health, Education and Welfare requires that the Department of Social Services place special emphasis on the necessity of early and periodic screening and diagnosis with respect to children in aid to dependent children families to ascertain physical and mental defects and provide treatment for conditions discovered. Primary attention is to be directed to assuring at this time that children under age six in aid to dependent children families receive such screening examinations. The essential components of a screening examination that have been specified by the federal agency are as follows:

1. Physical Measurements
2. Unclothed Physical Inspection

3. Developmental Assessments
4. Vision Screening
5. Hearing Screening
6. Ear, Nose, Mouth, Throat and Teeth Inspection
7. Hematocrit or Hemoglobin
8. Rapid Urine Screening
9. Review of Immunization Status

When Appropriate

10. Sickle Cell
11. Serology
12. Lead Poisoning
13. Cardiac Auscultation

The Bureau of Medical Services of the State Department of Social Services has estimated there are 22,528 children in Iowa under six years of age eligible for this service. On July 1, 1973, the age of persons to be served is raised to 21 years. The total number then eligible will be about 70,000.

At the present time some physicians are performing these examinations in their offices. In other areas where physicians are unable to examine or prefer to have them done otherwise, public health nurses are screening. Some of these nurses have received and others will receive some hours of extra training for this task.

It is hoped that in many communities a child health conference and an Early and Periodic Screening for Diagnosis and Treatment conference may be run with the same personnel or indeed may be the same clinic.

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WHO IS THE PEDIATRIC NURSE PRACTITIONER?

"Many functions and other aspects of the pediatric nurse practitioner's role are not revolutionary or new to nursing theory. Indeed, basic nursing education is now increasing the preparation of nurses in health maintenance skills. However, the health care system in which a nurse is placed has not, until very recently, allowed her to use her potential.

"Disuse of knowledge and skills results in atrophy so that for many nurses, refresher training in this area is called for. Because the lack of opportunity to assume responsibility and display initiative invariably result in excessive dependency, role reorientation is also needed."

The American Nurses' Association and American Academy of Pediatrics have collaborated in developing guidelines for short-term continuing education courses for pediatric nurse practitioners. The University of Iowa currently offers a program typical of many over the country in which registered nurses already working in child health care settings take training at the University for 12 to 16 hours a week for 16 weeks. The education encompasses both academic and clinical areas. Faculty are from the College of Nursing and the Department of Pediatrics.

There is also a master's degree program as a part of Nursing of Children.

A pediatric nurse practitioner program builds on nursing knowledge and skills acquired in basic nursing education and also provides some knowledge and skills that are usually accepted as the physician's province, e.g., physical examination includes use of otoscope and stethoscope.

In a survey of the Denver area more than half the parents taking their children to private pediatricians who employed a pediatric nurse practitioner said the services were better than those received from the pediatrician alone. Most of the other parents stated the care was "equivalent." Only 5 per cent were dissatisfied.

Silver and Duncan evaluated the technical skills of the nurse by comparing outcomes of nurse and pediatrician assessment of 180 children (half ill, half well). There were few "over-referrals" by the nurse. No more missed diagnoses than expected in the course of routine pediatric practice were reported.

The pediatric nurse practitioner is seen as a valuable member of the child care team who can help greatly to extend diagnostic and therapeutic services.

ONCE EACH YEAR THE JOURNAL OF THE IOWA MEDICAL SOCIETY *is pleased to pay special tribute to The University of Iowa College of Medicine. This is accomplished by designating April the University Issue. We regard our 1973 University Issue as more meaningful than many of its predecessors in that it contains presentations which when taken together constitute an actual status report on the College of Medicine. In lieu of his customarily brief introductory comments, John W. Eckstein, M.D., Dean, College of Medicine, has kindly responded to several seemingly pertinent questions which the* JOURNAL *has directed to him. We appreciate his succinct, yet clear responses. We invite you to read his comments and the other reports on the College of Medicine which appear on the ensuing pages.*



UNIVERSITY ISSUE

JOHN W. ECKSTEIN, M.D.
Dean, College of Medicine

How would you characterize the status of The U. of I. College of Medicine at this time?

We find ourselves at a most important threshold. The 1970's will unquestionably represent one of the greatest periods of growth in the history of the College. Next year we will have a total enrollment of nearly 700 medical students, an increase of 40 per cent in a period of four years. With our enlarged student body, we will experience a need for increased clinical facilities, as well as a demand for more residencies. For this reason we have been moving forward with the development of educational affiliations with community hospitals throughout the state. Formal affiliation agreements have been signed with Mercy Hospital in Iowa City and Mercy Hospital in Mason City, and a similar arrangement with Iowa Lutheran Hospital in Des Moines is in the final stage of completion; our long-term relationship with Broadlawns Hospital in Des Moines has been strengthened; and a plan for area wide health education centers throughout the state suggests the desirability for expanding such relationships to other hospitals. We find ourselves, however, with significant unmet needs for our present expanded operation in the presence of sudden enormous cuts in federal support of programs that have been accelerating during the past 18 years. We share with other medical schools the extremely difficult

problem of recreating a sound financial base from which to move forward. We tend to be optimistic, but it is clear that adjustments in both new and existing programs may be necessary.

What is the enrollment picture? Are there still many more applicants than spaces available? Is the admissions process working reasonably well?

Applications numbering 1,225 were received for the 175 places in next year's class. Nearly 400 of the applications were from Iowa residents. At this time it appears about 92 per cent of the successful applicants will be Iowans. Despite this emphasis, it is inevitable a large number of qualified Iowa applicants must be declined admission, and this circumstance naturally results in major disappointments—both to student applicants and to their families. We believe, however, we have a much improved system for providing the information we need and for keeping the student applicants informed throughout the various stages in the admissions process.

Are the curriculum revisions of the past several years being well accepted by students and faculty? Could you summarize what changes have been implemented?

You will recall the new curriculum was planned in 1967 and inaugurated in 1969-70. It has been reviewed and further implemented in each succeeding year. The program as unanimously approved by the faculty may be summarized as follows:

1. The principal basic science curriculum is presented during the first three semesters and focuses on carefully selected core material based on statements of objectives that are reviewed each year by the Medical Education Committee.

2. Interdisciplinary programs in genetics, endocrinology, neurobiology and a course designed to ensure that students can evaluate new advances in medical information are included in this three-semester period.

3. The Introduction to Clinical Medicine occupies the fourth semester and integrates basic science and clinical principles. This course provides a thorough training in the basic clinical skills and the fundamentals of human pathophysiology.

4. The clerkships are presented during the third year as a series of rotations through the various clinical services.

5. The senior year is a period of selective study and it may be arranged to fit the career objectives of the student.

6. An increased amount of unscheduled time is provided to allow for independent study even during the first semester.

7. Many self-instructional approaches are utilized in the basic science and clinical programs, and an emphasis is placed on the selection of areas of particular interest by students. Further, the possibilities for students to proceed at different rates are being explored by the development of modular learning programs.

The changes have been well received by both students and faculty. Because this curriculum takes a great deal more of the faculty's time than did the former system, there are stresses which shall be relieved only when we are in a position to increase the numbers of our faculty, in accordance with the original plan.

Could you identify and report briefly on those new programs which are of particular interest to Iowa physicians, e.g., physician's assistants, family practice?

The first class of 10 physician's assistant students is completing its first year of the two-year sequence, and plans are moving forward for acceptance of 20 students in the fall of 1973. The Department of Family Practice continues to move forward vigorously in planning for increased residency training and direct interaction with community primary care physicians. The Model Rural Health Clinic at Oakdale is now functional, providing both care for the population area served and a teaching model for students at all stages of undergraduate and graduate education.

The matter of continuing medical education has been in the spotlight. Could you comment on the involvement of the College in this area?

The College recognizes a large responsibility to its "student body" of practitioners who, in turn, recognize their individual life-long re-

sponsibility to be students of medicine. We strive increasingly to respond to practitioners' educational needs, within the constraints of our personnel and fiscal capacity. Our Office of Continuing Medical Education has been able to increase our outreach contact with many Iowa communities and medical groups, in addition to arranging personalized traineeships in the Medical Center and a continuing series of fine courses and workshops in Iowa City. Last year we provided 110 offerings to 4,914 registrants. Assisting physicians and hospitals to develop effective local methods for continuing medical education is an activity of great importance which we'll be sharing increasingly with the practicing community.

What physical facility projects are in process at University Hospitals?

The southeast corner addition to the University Hospital is providing increased office, clinic, and teaching space for the Departments of Surgery, Otolaryngology, Internal Medicine, Urology, and Anesthesia. Construction of the O'Brien Learning Center in Ophthalmology is moving forward, and increased clinic space is being provided for Pediatrics. Construction of the North Tower Addition to the University Hospitals of some 168,000 gross square feet is in the planning stage. While no increased beds will result, this construction will permit phasing out of the open wards, expanding outpatient areas for Medicine, Surgery, Dermatology, and Obstetrics & Gynecology, and will provide increased space for Radiology and more operating rooms. The location will maximize the functional relationship of the out-patient, inpatient, and service areas of the Hospital at the lowest cost for construction.

Is the College holding its own in the competition for faculty?

Our faculty workloads have increased tremendously in the past few years because of enrollment increases in all the health colleges, yet we have approximately the same number of faculty today as in 1969-70. Based upon what we consider a reasonable faculty workload, we need 60 additional faculty members right now. This year we were able to slow the accelerated attrition rate of the previous year through much needed salary raises last July 1, bringing us better in line with our competition. Whether we will be able to maintain our relative competitive strength is a matter of conjecture at this moment because of the enormous cutbacks in federal support.

The College has sought to be supportive of the practicing physicians in Iowa for many years. Are there new efforts in this area which could be mentioned?

I mentioned earlier our extensive efforts in continuing medical education, particularly those developing programs at the local level. We believe that we will be enriching the professional environment by developing community-based residency programs in Family Practice and other specialties. The number of telephone exchanges between our clinical faculty members and the physicians of Iowa and the region have been estimated to be far in excess of 10,000 per year, covering both specific patient consultation questions and general information. Of particular visibility of late has been the increased interaction between the College and family practitioners throughout the state. And of course, we feel we offer highly valuable support to all practitioners by making available the latest diagnostic and therapeutic facilities, in fulfillment of our role as a tertiary care center.

How can the Iowa physicians be more supportive of the College program?

We hope that Iowa physicians would be supportive of the needs of the College, as represented in the legislative askings of the State Board of Regents for the University of Iowa. And we encourage the continued interest and support in our expanding community teaching programs, including community-based student preceptorships, the Medical Education/Community Orientation Program, and the establishment of new Family Practice residencies in selected community hospitals throughout the state. All Iowa physicians have recently received information about the new Medical Center Constitutent Society of the University of Iowa Alumni Association. Membership is open to nonalumni as well as alumni, and we hope all of Iowa's practitioners will take this means to increase our inter-dependent and mutually supportive relationships. And finally, we need the support that comes in the form of constructive criticism and friendship.

Iowa's Medical Curriculum—1973

GEORGE L. BAKER, M.D.
Iowa City

THE CURRICULUM IN MEDICINE at The University of Iowa is based on a strong tradition of excellence. It is being evaluated and renewed continually, so that it reflects the changing needs of the new physician and of society. From 1969 through 1973 a major revision has been in process. This report describes the curriculum resulting from that revision.

GENERAL PLAN

The faculty of the College has full responsibility for the curriculum. It seeks advice and counsel from students, physicians of the state, educators, and others with interest and ability in medical education. The College has led the nation in defining its curriculum goals and objectives at the college level and specifically for each course or clerkship. A principal goal is to help students realize their studies do not end with graduation but continue and expand throughout their professional careers.

The curriculum is divided into three semesters of basic medical science and five semesters of study in clinical medicine. The basic science study is designed specifically for medical students and material is presented in discipline-oriented courses. This information is reviewed using an organ system approach during the fourth semester in a program that serves to introduce students to clinical practice. The combination of the two major approaches to basic science instruction enhances the ability of the student to utilize this information during the study of clinical medicine.

The clinical study is divided into three segments; the first is the general introduction referred to in the preceding; this is followed by a full year of required work which is followed in turn by two semesters of selective study. The year of required clinical work provides basic clinical education in a wide variety of medical disciplines. In the selective period a student may choose areas for further study which are most appropriate to his career goals.

Two periods of 3½ months are available as free time during which most students develop educational programs of their own choice and design. As will be discussed in the following, these breaks represent an important part of the total program.

BASIC MEDICAL SCIENCES

In the first three semesters a core of sciences basic to the study of medicine is presented. *Biochemistry* is centered around a series of clinical situations. The language of this discipline is presented in the context of problems which the physician will meet. Small group discussions follow in which the student starts to use various problem-solving approaches. While this is a considerable departure from the biochemistry course many will recall, it has proved to be an effective means of helping students learn the chemical events which are the basis of life and which provide the machinery for all of the responses that living systems exhibit.

Gross anatomy now includes a focus on living anatomy, study of functional and topographic anatomy, as well as providing an extensive experience in clinical problem-solving utilizing anatomic knowledge. A complete dissection of the human body is still undertaken but the relationship to the living system is stressed. *Microscopic anatomy* completes the work in the semester and provides a self-paced course of study for the core information concerning cellular and tissue structure and function needed for the work to be accomplished in physiology and pathology.

Dr. Baker is assistant dean for student affairs at The University of Iowa College of Medicine. He is also an associate professor in the Department of Pediatrics.

In the second semester, *Medical Physiology* and *Medical Endocrinology* afford the student an understanding of the responses an organism gives to external stimuli and provide a basis for understanding the integrated function of organ systems. Much of the material in these two courses is presented from a clinical point of view. In small discussion groups which have essentially replaced laboratory exercises the students present their evaluations of the physiologic mechanisms at work in the clinical material. Some demonstrations are used to good advantage. *Microbiology* includes immunology and presents a core of information on the classification and mode of action of infectious agents, as well as certain aspects of body response to these agents. Laboratory work continues to play an important role in this course. *Introduction to Pathology* is correlated with microbiology in this semester to increase the efficiency of the learning process. Much of pathology at this level is self-instructional with the student testing out of each segment as it is completed. Clinical problem solving and discussion periods have replaced laboratories in this course. Most students (greater than 95 per cent) have mastered basic *genetics* concepts prior to medical school. Remedial work is available for those who have not and then all students work through a programmed text which provides a structure on which to organize genetic information during their clinical study.

The summer following the first year is unscheduled and students exercise their freedom in a variety of ways. In 1972 about half (63) worked in Iowa hospitals and clinics through the MECO (Medical Education and Community Orientation) project. Another 25 to 30 worked in research laboratories, and 10 or 12 were in urban health projects. This free time is greatly treasured by students and most benefit considerably from it even though they may not engage in activities directly related to medicine. Maturation and personal growth are important aspects of a medical education and this break in the formal schedule provides time for assimilation following the first year immersion in the medical program.

The third semester includes *Systemic Pathology,* in which the principles given in the previous semester are expanded upon in an organ system approach. Student-centered learning is fostered by discussion groups and practice in case analysis. *Neurobiology* presents structure and function of the nervous system in an integrated course. Much of the material is available for self-study and small group study in carrels. An introductory course in *human behavior* is given during this semester. The fundamentals of *community medicine* are presented to help prepare the student in some of the sociologic aspects of medical practice. *Pharmacology* bridges the clinical and basic sciences and provides the students with principles that must be understood to properly prescribe the actions of drugs in the patient.

As noted, greater use of individually paced instructional units permits more efficient use of faculty and student time and enables the College to move toward a more flexible schedule.

INTRODUCTION TO CLINICAL MEDICINE

The Introduction of Clinical Medicine course fills the fourth semester. This major interdisciplinary course includes participation by a high proportion of the faculty and is vital in providing a student with the tools for a lifetime of patient care. The first series of mornings are devoted to introducing the patient as a person and giving guidance in interviewing, counseling, and history taking. Following this is an intensive review of clinical medicine on an organ system basis given by teams of clinicians and basic scientists. The final group of mornings is spent in those areas of medicine which do not naturally fall into organ systems and on re-emphasis of some key subjects. Throughout the 16 weeks of this course, afternoons are spent in acquiring and practicing the skills of the clinician in history taking and physical examination. Habits of care, concern, and compassion needed by all physicians are established in this semester. Toward the end of the semester, each student is evaluated individually several times to determine the level of skill achieved. If further work is needed, guidance and assistance are provided.

CLINICAL CLERKSHIPS

The third year includes the required clinical clerkships and presents a student with opportunities to work with physicians of almost all disciplines as they care for their patients. Nine weeks are spent in internal medicine, six weeks each in surgery, pediatrics, obstetrics and gynecology, and psychiatry, and two weeks each

in anesthesia, dermatology, neurology, otolaryngology, orthopaedics, urology, and primary care—preceptorships. Most of the time is spent in Iowa City. The clerkship year is the most critical time in medical education. This is the year in which the student takes on the posture of a physician. An awareness is developed of the complexity of medical science when viewed at the bedside, and of the awesome responsibility of the physician for human life. Most students find their behavior becomes conditioned to respond to the demands of illness, which knows no schedule. Experience has shown that students with a sound foundation and a continuous exposure to challenging problems soon develop the confidence so essential to the acceptance of the responsibility of medical practice, and if the clinical experience has been sufficiently challenging, they will have learned the necessity of humility in recognizing their limitations. The key to the clerkship year is to match the high enthusiasm of the student with a supervised intense clinical experience. The time span for this process is critical as is the nature of the clinical experience. If it is spread out over too long a period the student's enthusiasm wanes, and if the patient population is made up of interesting, but well people, confidence may develop out of proportion to competence. Many additional layers of instruction may be required to reclaim the student who has faltered during this critical period of training.

PERIOD OF INTENSIVE STUDY

Following the clerkships, the fourth year provides a period of intensive study when the student has many options. The broad comprehensive orientation to the different medical disciplines and the level of clinical sophistication achieved during the clerkship year qualify the student to participate in a variety of medical experiences ranging from advanced courses in specialty areas to community based clerkships in primary care. In the first year of this selective program approximately 15 per cent of the courses have been taken off campus, most of these in community hospitals. Projections are for 20 to 25 per cent of courses to be selected from off campus offerings in 1973-74. This program permits some students to select and prepare for the discipline for their career somewhat earlier, while permitting those who are undecided to sample broadly for a longer time.

EVALUATION

Several methods of evaluation are being used to compare the previous curriculum with the one described here. These will be reported as they are completed.

SUMMARY

The curriculum in medicine at The University of Iowa builds a strong general clinical program on a solid foundation of sciences basic to medical practice. It is the vital keystone in the continuum of medical education which permits the new graduate to enter successfully one of the many medical disciplines for graduate clinical training.

CANCER TRAINEESHIP FOR PRACTITIONERS

The University of Iowa College of Medicine offers a unique one-month traineeship in clinical oncology. The month will be tailored to suit the individual needs and problems of the trainee. The emphasis will be on an interdisciplinary approach to cancer. Practitioners of any background or medical discipline are eligible to apply.

The schedule will be individualized for the trainee to assure an interesting and appropriate experience. The traineeship provides credit hours for members of the Academy of Family Practice or toward the AMA Physician's Recognition Award. Those interested should contact Richard M. Caplan, M.D., Office of Continuing Medical Education, The University of Iowa College of Medicine, Iowa City, Iowa 52242.

Profile of Students Entering the College of Medicine At The University of Iowa

W. W. MORRIS, PH.D.
Iowa City

THIS REPORT will encompass students who have enrolled in the College of Medicine over the past seven years. With the accumulated data we can look at the current profile of personal and family characteristics of the medical students, and also note any changes that may have occurred in this time frame.

AGE, SEX, AND MARITAL STATUS

Over the years the average age of entering students has remained a consistent 22 years of age. The range has extended from as young as 19 to as old as 32.

The great majority of entering students have been men, but during this seven-year period the number and proportion of women students have increased steadily. Thus, in more recent years, women have comprised as many as 16 per cent of the entering class, while earlier the percentage was less than 10. There were 26 women students in the 1972 entering class (Figure 1).

More entering students are married now than earlier in the comparison period. Of the present freshman class, about one-third were married when they registered in August, 1972. This factor has a profound influence on the demands for loan and scholarship funds. Of additional significance in this realm is the proportion of upper classmen who are married. By the end of the sophomore year about half of the students are married, and two-thirds are married by graduation time.

Dr. Morris is an associate dean at The University of Iowa College of Medicine.

PARENTAL EDUCATIONAL & OCCUPATIONAL BACKGROUNDS

In recent years there has been a clear increase in the level of educational attainment of the parents of our medical students. Earlier in the period the fathers had on the average a high school education; currently they average one to three years of college. Similarly, the mothers have moved upward from less than high school graduation to some college-level education. A negligible proportion of parents has no education at the high school level.

Almost two-thirds of the fathers of University of Iowa medical students are in various professional or business occupations, the remainder being primarily in farming and agriculturally related work; a smaller proportion are in service and trade fields, or in clerical and sales occupations. Within the professional

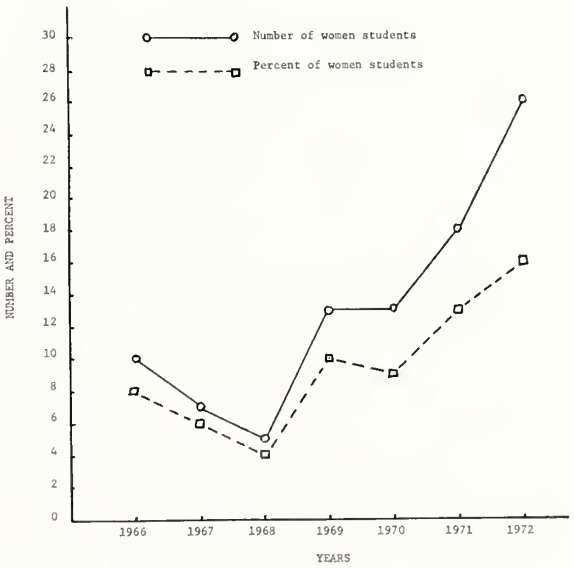


Figure 1. Graph shows number and percent of women students enrolled.

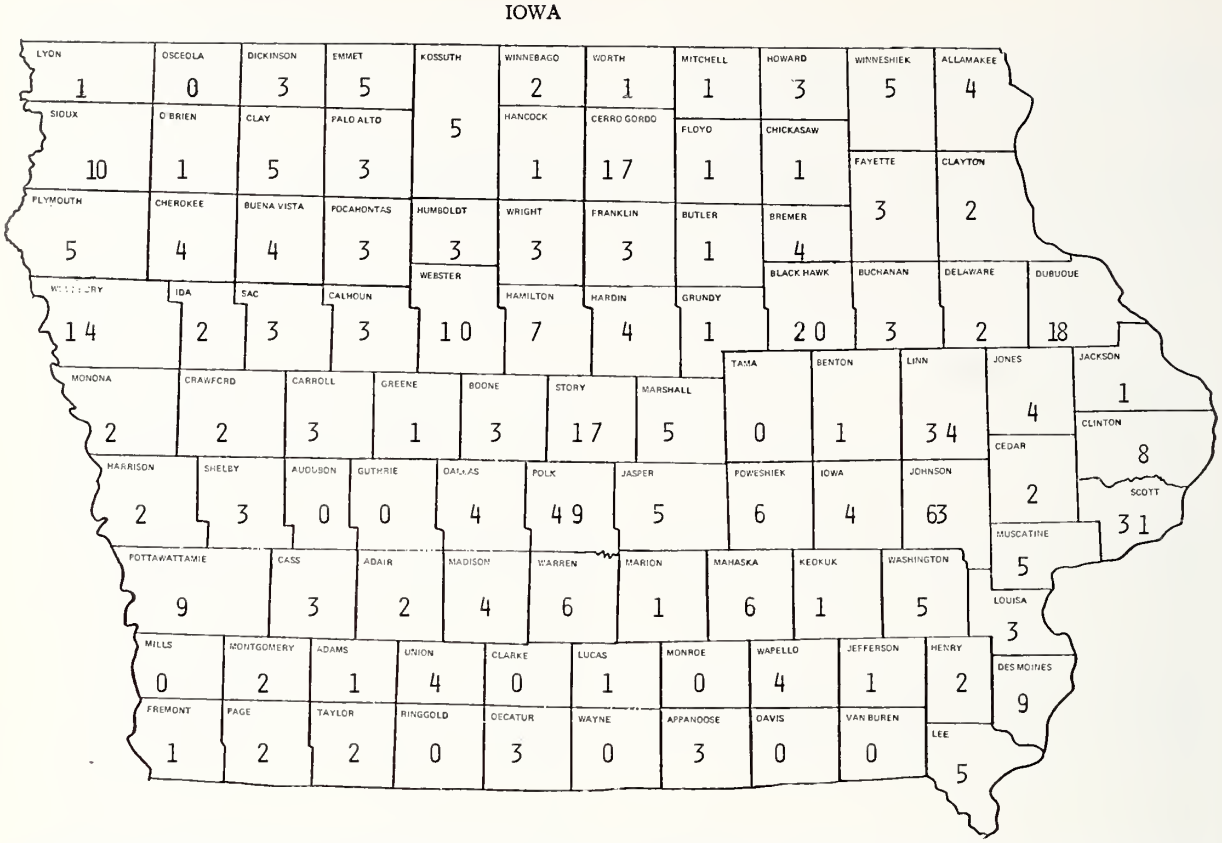


Figure 2. Iowa resident students currently enrolled in the College of Medicine (N=526). These data were taken from University registration materials on which married students list Iowa City as their home address, which explains the large number in Johnson County.

group, less than 20 per cent are in health-related professions (medicine, osteopathy, dentistry, optometry, veterinary medicine, pharmacy, and others), and over these years the range of fathers who are medical doctors has been from only 7 per cent to 16 per cent.

About half or slightly more of the mothers are not employed outside the home. Those who are gainfully employed work primarily in business and professional fields and to a lesser degree in clerical and sales work. The single most common occupation in the professional area is that of school teacher. In the clerical-sales area, office work is the most common.

The median income of the parents of our current first-year students is in the neighborhood of $15,000 per year. This has been steadily rising over the period—probably more a factor of general inflation than of increased affluence.

RESIDENT STATUS AND SIZES OF HOMETOWNS

By design the biggest proportion of our entering students are Iowa residents. The range over the period has been from about three-fourths (in 1969) to about 85 per cent more recently. Many of the nonresident admissions have come from states contiguous to Iowa. Thus, if the number of students admitted from contiguous states is added to those from Iowa, the entering class has been consistently about 90 per cent from this region.

By and large the distribution by sizes of hometowns is a remarkably "good fit" with the actual distribution of the Iowa population. In 1971 some 21 per cent of our students came from the open country compared to 26 per cent of the Iowa population. Consolidating the data also shows that close to half of our students come from small cities (under 10,000) and rural areas, about 60 per cent of the Iowa population lives in such areas.

Finally, there are few Iowa counties that do not have at least one medical student currently enrolled in the College of Medicine (Figure 2). In general, enrollment is closely correlated with county population.

Physician's Assistant Training Program: Questions & Answers

A. W. HORSLEY, M.D. and
T. D. ASCHENBRENER, R.P.A.
Iowa City

How was a Physician's Assistant Program initiated at the University of Iowa?

A program to train physician's assistants was developed by the College of Medicine to meet standards established by the American Medical Association and other national accrediting groups. Because appropriated funds were not available to support this new program, the College applied for support from the federal Bureau of Health Manpower Education (BHME) with a subsequent award of $125,000 one year renewable contract, beginning in 1972. In August, 1972, the State Board of Regents approved the establishment of a physician's assistant program contingent on federal funding. The first 10 students were enrolled in September of 1972; another 20 students will enroll in August, 1973.

What is the educational emphasis in the program?

All parts of the program have been structured to emphasize *general medicine,* with a goal of facilitating development of new approaches to health care delivery in rural and other health care deprived areas.

What kind of physician's assistant is being trained?

The physician's assistants being trained in the *two-year* program are being prepared to become assistants to primary physicians (those who have first contact with patients) because this is the area of greatest need in Iowa. The concept of physicians using assistants to carry out various routine tasks is not new; many physicians have trained their own assistants in the past. However, in recent years, it's been recognized that a skilled assistant with formal training is needed if we are to provide health care for everyone. Physician's assistants being trained at The University of Iowa will be prepared to assume *a high degree of responsibility in patient care.* Under the physician's direction and general supervision, the physician's assistant will perform many of the duties usually performed by the physician in the past. This will allow physicians to utilize their extensive training and experience to solve more complex problems and serve many more patients.

What kind of services will the assistant perform?

While specific duties assigned to graduates of the physician's assistant program will be decided by the employing physician, graduates are being prepared to provide the following services:

(1) receiving patients, obtaining initial histories, performing an appropriate physical examination and presenting the data to the physician in a meaningful manner; (2) performing or assisting in laboratory procedures and related studies; (3) giving injections and immunizations which may be hazardous; (4) suturing superficial wounds; (5) providing patient counseling services and facilitating referral of patients to other health services; (6) responding to emergency situations which arise in the physician's absence; and (7) assisting the employing physician in all settings—office, hospital, extended care center or nursing home.

These highlights of the new Physician's Assistant Training Program at The University of Iowa College of Medicine have been prepared in question and answer form by Arthur W. Horsley, M.D., assistant dean, Community Health Care and Allied Health Programs, and Thomas D. Aschenbrener, R.P.A., an administrative assistant.

The physician's assistant will not supplant the doctor in the sphere of the decision-making required to establish a diagnosis and plan therapy, but the assistant will aid in gathering the data necessary to reach decisions and in implementing a therapeutic plan for the patient.

Why does it take two years to train a physician's assistant?

For the physician's assistant to assume certain tasks traditionally performed by physicians requires intensive course work and clinical experience in general medicine. The educational program must prepare the assistant to perform certain specific tasks with *the same competence as a physician* to assure the employing physician, his patients and others that he possesses the necessary capabilities.

Would former military medical corpsmen need two years of training?

Because they have been trained primarily to attend to the kinds of problems unique to military medicine, all medical corpsmen would require additional training to assume the much broader responsibilities of the physician's assistant. Corpsmen, for example, do not receive training concerning the health problems of women, children, and the elderly. The military services now operate their own physician's assistants training programs modeled after the Iowa and Duke programs and corpsmen must take this additional training to qualify as physician's assistants. Other allied health careers which require much less additional training are available to corpsmen. Such careers would be comparable to the health technician, orthopaedic assistant, office assistant, etc.

What are the requirements for students to enter the Physician's Assistant Program?

The minimum requirements of the College of Medicine for students entering the program are: (1) a demonstrated competency in performing college level work; (2) good moral character and responsible job performance as attested to by character references; (3) sufficient health care experience to comprehend their future role as *dependent* practitioners in the health care system; (4) adequate performance on standard intelligence and personality tests; and (5) previous course work in chemistry and the fundamentals of biology.

Is preference given to any candidates?

Preference is given to qualified candidates who are residents of Iowa and who indicate a willingness to settle in rural areas and to those who already have negotiated positions with primary care physicians.

What subjects do students study in the first year?

Intensive classroom and laboratory study during the first year includes such subjects as anatomy, physiology, basic laboratory procedures, biochemistry, clinical pathology, microbiology, pharmacology, general and systemic pathology, clinical medicine and physical diagnosis.

What is the objective of the clinical phase of training in the second year?

During the second year, students receive supervised clinical experience in several medical disciplines to ensure that they will have sufficient understanding of patients, disease, and the diagnostic and therapeutic responses to disease. Under physician supervision, students will evaluate patients and follow their progress. In addition to a preceptorship with a primary care physician in Iowa, the required rotations in the second year include General Surgery, Pediatrics, Internal Medicine and Family Practice.

How can the skills of the physician's assistant be utilized most effectively?

Because the assistant to the primary care physician is being trained to function at a new level of responsibility in the health care system, the College of Medicine is doing studies to determine how physician's assistants can be utilized most effectively. Physician's assistants recruited by the College from other states are being integrated into the health care teams now being developed for the model community health centers at Oakdale and Muscatine. Experience gained at these centers will provide realistic demonstrations of the value of new and alternative approaches to health care delivery which can be used in similar areas throughout Iowa.

Why a Department of Community Health In a School of Medicine?

PETER ISACSON, M.D.
Iowa City

The Department of Preventive Medicine and Environmental Health of The University of Iowa College of Medicine has formally requested its name be changed to "Department of Community Health." This request is in small measure the result of faculty and staff irritation over the present cumbersome designation. The main reason however is to better identify the newer role of the Department.

This change is requested at a time when schools of medicine are being obliged to narrow their focus and shorten the period of training. How then can an individual department justify attempting to broaden its reach? The answer to this question involves much more than administrative niceties. We must go to the heart of the nagging questions: What is health and who should be responsible for it? From the standpoint of schools of medicine, the question becomes more specifically, "What is the role of physicians in the determination of health policies?"

Answering this question first requires a look at the history of preventive medicine or public health departments in schools of medicine. These began largely in response to the great infectious plagues of man. Early departments were heavily involved in bacteriology and sanitary engineering. Immunization was a major activity and preventive medicine came into full flower. Epidemiology, the study of the distribution and determinants of disease in populations, was born and grew in departments of preventive medicine or public health. The menace of infectious diseases diminished and the corresponding activities changed, but the basic goals remained intact. The basic thrust was retained, the concept of studying and handling diseases in large population groups.

It became apparent that epidemiology was useful not just in following the path of an epidemic of infectious disease, but in looking at the significance of distributional patterns of all diseases. The relationship of smoking to lung cancer, for example, was essentially an epidemiologic finding. Epidemiologists now look at conditions as disparate as birth defects and skiing injuries, but the central feature is the process of looking at them according to their distribution in large groups of people: How are they related to economic class, to ethnic group, to occupation? What environmental factors appear to be common? How does the pattern vary over the years or by season or geographic location? Closely allied and in some cases inseparable has been the discipline of biostatistics. This has been a natural union considering the necessity of dealing with patients as members of large population groups. It is now difficult to conceive of preventive medicine or public health departments without a strong base in biostatistics. Over the years departments of this type have gradually shifted from a concern with specific entities, such as infectious diseases, to a concern with a general discipline which can be applied to all areas pertinent to health.

MODERN PROBLEMS

This emphasis on methods of study has made these departments particularly receptive to modern problems of medicine and health. One of the biggest concerns of the day, and certainly one of the most publicized, involves the organization and delivery of health care. We can see now the most advanced biological skills serve little purpose if they cannot be applied to people in the greatest need. Whether

Dr. Isacson is professor and head of the Department of Preventive Medicine and Environmental Health at The University of Iowa College of Medicine.

this country is suffering a "health care crisis" can be debated, but it is hard to deny the severe health care distribution problems. The problems are national in scope. For example, relatively well-to-do rural Iowa areas present needs which are quite comparable in many surprising ways to those of large urban ghettoes. For various reasons, of which finances are only one, people are not receiving the health care this country is capable of delivering, and it is of no particular use to ignore the public demands. It is also of no particular use to jump to a quick political solution. Logical answers demand systematic study, and this study will, in turn, demand precisely the disciplines which have been mentioned, those of epidemiology and biostatistics.

SYSTEMATIC EVALUATION

Consider, for example, the problems faced by a community wishing to plan for a new and expanded health facility. First, there is the necessity for a systematic evaluation of needs. How should this be done? Is asking the opinion of local practitioners sufficiently precise or is a systematic population survey and health facility origin study needed? If so, how should it be done? What degree of randomization is necessary to prevent biased results? How large a sample is needed for statistical significance? What questions yield the most reliable and reproducible answers? How can the data be most efficiently retrieved and used? Finances must be considered—what payment mechanisms exist or which are potentially available? What is a fair monitoring mechanism? How can screening procedures be cost accounted and how many are needed according to existing risk groups in the community? And what is comparable documented experience from other areas? These represent only a small sample of the almost endless series of logical questions that should be considered and cover only one aspect of health care organization and delivery. Physicians can, if they wish, ignore many of these aspects on the grounds that many are technical procedures to be carried out by others. This would be quite comparable to never being exposed to laboratory methods or a microscope during training on the grounds it may never be necessary to do the tests in practice.

The issue then comes back to that raised in the beginning: the degree to which physicians should be trained in these areas. There has always been a tendency to make physicians all things to all people. A growing body of public opinion suggests now that physicians ought not to have such a large share of decision making in health policies since they are not well trained in many of the important areas. As with many complicated social-medical issues, there is a certain grain of truth to this argument. Physicians are still taught almost exclusively to look at a single patient, to diagnose and treat on an individual basis. Newer concepts of public health have a difficult time gaining a place on the curriculum. There are several entirely understandable reasons for this. For one thing, public or community health is a comparatively young field, without the vast heritage of many other fields. A student may spend an enormous amount of time studying gross anatomy, for example, learning essentially the same things his father and his grandfather did. C. P. Snow once remarked it is easier to start a revolution than to change a curriculum.

LIMITED EXPOSURE

The high point of a medical student's life comes when he sees his first patient, and he sees him as an individual, not as one nameless member of a large population group. This natural tendency has not been altered much by the quality of teaching in public health. All of us of a certain vintage remember painfully our public health instruction. It usually consisted of a few Saturday morning lectures on privy building, interspersed with a field visit to the local sewage treatment plant. The image of the public health physician has also been less than exalted. The field has always attracted a few dedicated, truly outstanding individuals, but all too often a different type emerged. My own favorite example was a public health physician who told me he entered the field because "after my last coronary I knew I had to slow down."

There is at least partial support for the contention that the American physician is not well trained in many of the areas pertinent to health. Perhaps, the reasoning goes, this is not a bad thing and the physician should restrict

his role in the development of health policy to consultative advice on medical management of symptoms. Broad policy decisions can then be left to the social planners. I believe this would be a mistake. The practicing physician is on the front line of health care, and to diminish his role in health care planning would do nothing more than lead to an unworkable and poorly conceived system. The answer quite clearly is to provide him with more of the necessary tools so his voice is clearer, so the concept of the community as a patient becomes a real one.

This, then, is the answer to the question of the title, "Why a Department of Community Health in a School of Medicine?"

Growth of Blood Transfusion Services At University Hospitals and Clinics

JOHN A. KOEPKE, M.D.
Iowa City

SHORTLY BEFORE World War II, in October 1938 to be exact, Dr. Elmer DeGowin founded one of the first medical center blood banks in the country at The University of Iowa Hospital. In the intervening years, this bank has grown in to one of the largest transfusion services in the country. In the past year over 24,000 units of blood or blood components were given to patients at The University of Iowa Hospitals and Clinics. About 13,500 of these units were transfusions of whole blood or packed red cells. The transfusion of whole blood and red cell packs has increased at a rather modest rate; the increase was about 24% in the last decade. However, the transfusion of blood components, primarily cryoprecipitate for the treatment of hemophiliacs and platelets for the acute care of some thrombocytopenic patients, has skyrocketed to approximately 11,000 units per year. This represents a twenty-fold increase when compared with the amount of these components given just five years previously. Truly the use of blood components has come of age.

Due to the University's location in a comparatively small town of about 50,000 inhabitants, we are largely dependent on outside sources for blood and blood components. Otherwise Iowa City residents would have to donate at a rate 10 times the national average of 3-4% to supply the voracious needs of our transfusion service. Because of the increasing awareness of the transmission of hepatitis by transfusion of "commercial" blood, blood banks throughout the country have been rapidly decreasing the use of blood from paid donors in an effort to avoid this problem. Similar trends have been evident at The University of Iowa even though the commercial sources of blood used here seemed remarkably free of hepatitis risk. The largest amount of commercial blood was purchased here in 1967 when almost 7,600 units of blood were obtained from such sources. After that time this source of supply has been reduced gradually until April, 1972 when University Hospitals stopped using commercial blood.

Replacing this rather large amount of blood from other sources has constituted a significant problem. We are working to increase local donations, and we have increased the number of units obtained from cooperating Iowa blood banks and also the American Red Cross. This has put some stress on these facilities.

Due to the rapid expansion of the component program, we face the further problem of needing donors to come to the University Hospitals so these short-lived components, especially platelets, can be appropriately prepared for

Dr. Koepke is professor in Department of Pathology at U. of I. College of Medicine and Medical Director, Blood Transfusion Service.

patient use. It is here that our problems are especially acute.

Blood replacement rates in recent years have averaged about 27% with the rest obtained from a variety of sources. National awareness of the problem hopefully will stimulate blood replacement throughout the country. For example, the American Association of Blood Banks (which incidentally has accredited our bank) has set a goal of 100% voluntary replacement by 1975. Whether this is possible in this blood transfusion center is problematical at this time. However, we are committed to increasing significantly our replacement rates. To that end, a new donor center has been opened recently at The University of Iowa and it more than doubles our ability to receive blood donors.

It is our hope Iowa City physicians and also those others around the state who treat patients requiring blood will remind their patients' families and friends of the continuing need for blood replacement. Physicians are by far the best recruiters, but in their busy practices many times they neglect to remind their patients of this need. It is only by a continuing reminder process that we can maintain the transfusion service and meet the continually increasing demand for blood and blood products.

Closer cooperation with surrounding blood banks, the possibility of mobile donor facilities, efforts to increase efficiency in blood usage, and decreasing outdating of blood are all included in the future planning for the transfusion service at The University of Iowa. The service stands ready to help other transfusion services throughout the state in any way it can.

By careful and well-conceived planning it is hoped we can avoid some of the difficulties anticipated in the rapidly advancing evolution of blood banking in this country. As you are well aware, blood banking has entered the political arena. The national goal for the provision of blood services: the provision of an adequate supply of blood and blood products, of the highest quality, readily accessible to all in need, at a reasonable cost, can hardly be faulted. Closer cooperation with all health providers should help us to approach this goal.

SERVE ON COMMITTEES OF COLLEGE OF MEDICINE

Twelve Iowa physicians currently serve on committees of The University of Iowa College of Medicine. The College recognizes the important insights brought by these busy practitioners, and acknowledges their fine contribution. These committee positions have their parallel with the faculty members who serve on committees of the Iowa Medical Society—both providing important avenues for dialogue and help with our mutual and inter-related challenges. The College is pleased to extend its appreciation to these practitioners:

ADMISSIONS COMMITTEE

John Tyrrell, M.D., Manchester
R. D. Whinery, M.D., Iowa City

PRECEPTORSHIP COMMITTEE

Lynn D. Caraway, M.D., Amana
James D. Kimball, M.D., Osceola
John R. Scheibe, M.D., Bloomfield

CONTINUING MEDICAL EDUCATION COMMITTEE

Arthur Barnes, M.D., Cedar Rapids
David Kapp, M.D., Dubuque
John MacGregor, M.D., Mason City
John Murphy, M.D., Boone
Roy W. Overton, M.D., West Des Moines
John Rhodes, M.D., Pocahontas

CANCER COMMITTEE

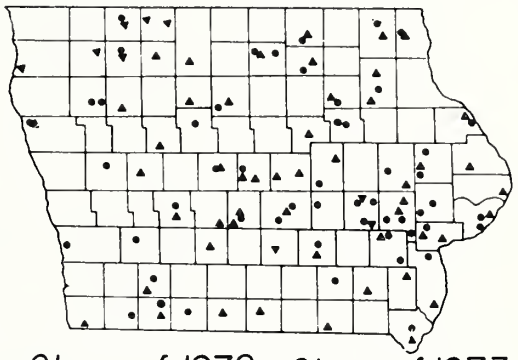
L. Robert Martin, M.D., Cedar Rapids

The College Thanks Iowa Preceptors

In the 1971-72 academic year, two classes of medical students served two-week preceptorships in primary care. For the graduating class of 1972, 101 physicians from 53 Iowa communities were preceptors for 124 students. For the class of 1973, 103 physicians from 63 Iowa communities were preceptors for 125 students.

Although we list the individual preceptors here to identify the one principally responsible, many other physicians have contributed to this important educational program. Group practices and "student-sharing" among solo practitioners helped to permit the students to encounter multiple practitioners, and correspondingly, a variable number of physicians enjoyed the stimulation of contact with bright student-physicians. To all those groups and individuals we extend our sincere respect and appreciation.

This program is an important element of our outreach effort—to permit students to have a look at the clinical problems and opportunities of medical practice away from the academic health center. The students value this portion of the curriculum. Increasing numbers of them



will be choosing elective preceptorships in their fourth year. For the great interest and cooperation of so many practicing physician-teachers, the College of Medicine is deeply grateful.

1971-72 PRECEPTORS

SERVED STUDENTS FROM CLASS OF 1972

Amana — Harold Moessner, M.D.
Ames — Louis Banitt, M.D.
Lowell Bond, M.D., R. M. Brugger, M.D., Thomas J. Dry, M.D., Kennedy Fawcett, M.D., Lee Rosebrook, M.D.
Anamosa — Aaron P. Randolph, M.D.
Atlantic — Keith Swanson, MD.
D. E. Wilcox, M.D.
Aurelia — Richard Berge, M.D.
Boone — Ralph L. Wicks, M.D.
Cedar Falls — Donald Penly, M.D.
Cedar Rapids — Carl R. Aschoff, M.D.
Maurice Estes, M.D., Julius Pietrzak, M.D., Richard Quetsch, M.D., Thomas J. Schueller, M.D., Robert L. Swaney, M.D., James Utter, M.D., G. L. VanSlyke, M.D.
Charles City — W. P. Pelz, M.D.
Cherokee — James H. Wise, M.D.
Clarinda — Willard G. Kuehn, M.D.
Clear Lake — James Y. Hendricks, M.D.
Coralville — Charles A. Skaugstad, M.D.
Corning — J. C. Nolan, M.D.
Council Bluffs — Gordon Neligh, M.D.
Davenport — John Collins, M.D.
Decorah — James Bullard, M.D.
Denison — James L. Flood, M.D.
Denver — E. H. Stumme, M.D.
Des Moines — Robert W. Anderson, M.D.
Harold Eklund, M.D., Don C. Green, M.D., Norman Tubb, M.D., Carlton W. Van Natta, M.D.
Dubuque — John Chapman, M.D.
David Kapp, M.D., B. F. Merrit, M.D.
Eagle Grove — James Blackman, M.D.
Dale A. Harding, M.D.
Eldridge — R. P. Lagoni, M.D.
Fayette — Scott Linge, M.D.
Fort Dodge — Richard H. Brandt, M.D.
Forrest G. Dannenbring, M.D., Francis E. Giles, M.D., James McNeil, M.D.
Fort Madison — Harry B. Helling, M.D.
Grinnell — H. Raymond Light, M.D.
Guthrie Center — Herbert Neff, M.D.
Donald W. Todd, M.D.
Iowa City — Oscar C. Beasley, M.D.
Thaddeus T. Bozek, M.D., Victor G. Edwards, M.D., Larry Rigler, M.D., Craig M. Champion, M.D., Anthony Colby, M.D., Loraine Frost, M.D., Richard Hockmuth, M.D., Lewis H. Jacques, M.D., Kenneth Judiesch, M.D., Karl Larsen, M.D., John R. Maxwell, M.D., Thomas R. Nicknish, M.D., Arthur Wise, M.D.

Kalona ..... Charles Beckman, M.D.
Dwight G. Sattler, M.D.
Lennox ..... R. W. Boulden, M.D.
Lone Tree ..... Keith F. Mills, M.D.
Marengo ..... Burns Byram, M.D.
Mason City ..... Gerald L. Brady, M.D.
H. J. Roddy, M.D.
Monticello ..... Otto E. Senft, M.D.
Mount Ayr ..... Duane E. Mitchell, M.D.
Newton ..... Stuart Sybesma, M.D.
Osage ..... Richard Boeke, M.D.
Oskaloosa ..... N. L. Saxton, M.D.
Ottumwa ..... R. D. Dalager, M.D.
Edward Ebinger, M.D., John E. Rawls, M.D.
Prairie City ..... J. Veverka, M.D.
Sioux City ..... Martin Zucker, M.D.
Spencer ..... F. D. Edington, M.D.
George F. Fieselmann, M.D., J. E. Kelly, M.D.
Spirit Lake ..... Maurice W. Kirlin, M.D.
Donald F. Rodawig, M.D.
Tipton ..... R. W. Kent, M.D.
Otto E. Kruse, M.D.
Toledo ..... Charles Maplethorpe, M.D.
Wapello ..... Leslie Weber, Jr., M.D.
Washington ..... Gerald Nemmers, M.D.
Waterloo ..... Robert Bailey, M.D.
William Drier, M.D., Robert Morrison, M.D., Thomas R. Spragg, M.D.
Waukon ..... Alden Wiley, M.D.
West Branch ..... Richard G. Stuelke, M.D.
West Liberty ..... Howard C. Palmer, M.D.
Williamsburg ..... Desmond Waters, M.D.

SERVED STUDENTS FROM CLASS OF 1973

Algona ..... Dan Bray, M.D.
Anamosa ..... Aaron P. Randolph, M.D.
Ames ..... Ralph M. Brugger, M.D.
Paul Koellner, M.D., William C. McCormack, M.D., Elroy R. Peterson, M.D.
Armstrong ..... Claire V. Lindholm, M.D.
Bettendorf ..... W. Ramsey, M.D.
Bloomfield ..... Mark Pabst, M.D.
Henry Perry, M.D.
Boone ..... Ralph L. Wicks, M.D.
Burlington ..... George Gundrum, M.D.
Jo Ellen Hoth, M.D., Warren Zabloudil, M.D.
Carroll ..... James McGill, M.D.
Cedar Rapids ..... Carl R. Aschoff, M.D.
Percy Harris, M.D., Robert L. Swaney, M.D.
Charles City ..... W. P. Pelz, M.D.
Cherokee ..... Thomas Gary, M.D.
Clarion ..... R. C. Eaton, M.D.
C. P. Hawkins, M.D.
Clear Lake ..... Robert Borgman, M.D.
Clinton ..... G. D. Aurand, M.D.
Conrad ..... Glendon Button, M.D.
Dohn R. Kruschwitz, M.D., R. K. Patterson, M.D.
Corning ..... J. C. Nolan, M.D.
Corydon ..... K. A. Garber, M.D.
T. W. Davis, M.D.
Davenport ..... Forrest Smith, M.D.
Gordon Cherwitz, M.D.
Decorah ..... J. A. Bullard, M.D.
Des Moines ..... Stewart Olson, M.D.
Philip S. Pugh, M.D., Jack Spevak, M.D.
Dubuque ..... David Kapp, M.D.
Herm Hein, M.D.
Dysart ..... Robert Linthacum, M.D.
Emmetsburg ..... James Coffey, M.D.
Estherville ..... Richard Bose, M.D.
John Powers, M.D.
Fairfield ..... W. C. Baumann, M.D.
James Dunlevy, M.D.
Grinnell ..... H. Raymond Light, M.D.
Grundy Center ..... M. Vanden Bosch, M.D.
Guthrie Center ..... Donald Todd, M.D.
Hamburg ..... Frederick Ashler, M.D.
Hartley ..... John Peterson, M.D.
Hawarden ..... Edward Eneboe, M.D.
Humboldt ..... James Coddington, M.D.
Iowa City ..... Oscar Beasley, M.D.
Thaddeus Bozek, M.D., Craig Champion, M.D., Anthony Colby, M.D., Victor Edwards, M.D., Charles Eicher, M.D., Loraine Frost, M.D., Karl Larsen, M.D., John Maxwell, M.D., Thomas Nicknish, M.D., Larry Rigler, M.D.
Kalona ..... Charles Beckman, M.D.
Dwight Sattler, M.D.
Keokuk ..... Joseph Rapagnani, M.D.
Knoxville ..... E. J. McKeever, M.D.
Lake City ..... Paul Ferguson, M.D.
Leon ..... Thomas McMillan, M.D.
Maquoketa ..... John Broman, M.D.
Marengo ..... Burns Byram, M.D.
Marshalltown ..... L. O. Goodman, M.D.
Edward Jacobs, M.D., David Winter, M.D., Curtis Wuest, M.D.
Mount Vernon ..... Gordon Rahn, M.D.
Muscatine ..... William Catalona, M.D.
Nevada ..... Robert Eggers, M.D.
Newton ..... Marvin Moles, M.D.
Oelwein ..... Donald Ottilie, M.D.
Osage ..... Richard Boeke, M.D.
Oskaloosa ..... Robert Collison, M.D.
N. L. Saxton, M.D., Sidney Smith, M.D.
Sioux City ..... Harry Robison, M.D.
Martin Zucker, M.D.
Spencer ..... George Fieselmann, M.D.
Spirit Lake ..... Carol Plott, M.D.
Donald Rodawig, M.D.
State Center ..... Ray Robinson, M.D.
C. R. Sokol, M.D.
Storm Lake ..... Paul Brecher, M.D.
Van Meter ..... Alan Felter, M.D.
Urbandale ..... Carlton Van Natta, M.D.
Waterloo ..... John R. Moes, M.D.
Thomas Spragg, M.D.
Waukon ..... Louis Bray, M.D.
C. R. Rominger, M.D., Bill R. Withers, M.D.
Waverly ..... A. M. Harwood, M.D.
James Rathe, M.D.
West Branch ..... Richard Stuelke, M.D.
West Liberty ..... Howard Palmer, M.D.
West Union ..... Larry Boeke, M.D.
Williamsburg ..... Donald Miller, M.D.
Winfield ..... R. B. Widmer, M.D.
Winterset ..... John E. Evans, M.D.

The Evaluation of Patient Care —Some Issues

ROBERT B. WALLACE, M.D.
Iowa City

THE MEDICAL CONSUMER expects quality control in health services just as he does for the other goods and services he purchases. This may not necessarily be due to any perceived inadequacy in health services, but rather to cost pressures or increasing expectations. The patient can know if he is being treated compassionately, how much he is inconvenienced, or how much his care costs. But he has variable insight into the amount of professional competence he is confronting. His often limited knowledge will hamper him in bringing a sign or symptom to a physician's attention, unless obviously severe, or in knowing when screening or preventive services are appropriate. Even if his perceptions are correct, the various services may not be available. Today's broad discussion of new organizational forms of health care delivery has sharpened the public concern for quality health services.

The patient does not have a "consumer report" to aid him in the medical marketplace. The recommendation of his friend or neighbor does not simplify the problem. Such advice may delay a visit to the physician as much as it may expedite it. All practicing physicians have licenses (by legal definition) and are graduates of competent medical schools, but these ornaments on the office wall are of little help. So, out of frustration, ignorance, and perhaps a general desire for excellence, the consumer has sought counsel. Responses have come from widely diverse areas: universities, which have conducted much health services research and experimental design; government, which has supported university research and conducted its own, and which also has tried to evaluate that portion of medical care it finances; lay organizations designed either for self-help or consumer advocacy; third-party financing organizations, which feel pressures to keep costs down; private foundations, which support health care research and innovation; and, of course, the medical profession itself.

Evaluation of the quality of health services may serve purposes other than improving cost efficiency and mollifying public sentiment. Competent evaluation methodology is necessary if recertification of health practitioners is to exist. An evaluation component is virtually always required when public and private agencies fund new or innovative health care programs, and is necessary in research in these areas. Finally, one or more practitioners may wish merely to evaluate objectively some aspect of their own practice.

LITTLE IN USE

While the health care literature contains an ever increasing number of models, structures, and discussions of health care evaluation, little has been applied or is in common use. Reasons include general complexity, lack of applied expertise among many providers of health services, extra resources in personnel, time and money required, and, sometimes, reticence of the medical profession to accept outside scrutiny. But, more fundamentally, it seems fair to say that all the methodology, while constantly improving, is probably not refined or efficient enough yet to evaluate all phases of medical practice in a truly satisfying way, in part because said practice is a mosaic of innumerable judgments, situational determi-

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nants, an ever changing and increasing body of knowledge, and complex interpersonal communications.

The most common form of medical care quality evaluation in current usage is peer review. This is basically the evaluation of patient diagnosis and management by a physician's professional colleagues who scrutinize medical records. Today, peer review is most frequently concerned with appropriateness of hospital utilization when the costs are borne by a third party carrier, including the federal government.

The depth of peer reviews varies now, but it is going to increase greatly in the next few years. The biggest step will be to include outpatient care. This type of evaluation will equal or surpass the challenge represented by the hospital's more structured setting. Primary concern will be with technical medical competence, but attention will also be given to fee structures, laboratory utilization, comprehensiveness of services, blood banking, prescription habits, emergency room usage, preventive services, and so on. Few elements of medical care will remain untouched.

Typically in peer review a set of evaluation criteria are constructed in advance. These criteria may be simple and answered with implicit, subjective judgment by a medical panel. For example, does the patient belong in the hospital? Failure to meet the criteria may result in withholding third party payments, at least until an appeal mechanism is set into motion. Usually the appeals board will consist of representatives of the third party and designees of state and local medical societies.

PEER REVIEW PROBLEMS

Several problems of peer review as currently practiced arise. Who should pay for the cost of the reviewer's time? Who is a peer? Should an internist be evaluating a family practitioner? Should an academic physician evaluate a community physician? Could non-physicians be utilized to conduct reviews to save physicians' time? Who should evaluate a physician's assistant? Who should select and be responsible for updating review criteria? What role, if any, should the medical consumer play? None of these questions have been answered in a uniform, totally acceptable way. Rather, each medical community is beginning or should begin to develop its own tentative scheme, which can then evolve over time into a more standardized approach. The recently passed H.R. 1 legislation, requiring the establishment of professional standard review organizations, responds to the preceding questions, but has left most of the specifics for peer review conduct in the hands of the medical profession.

It is obvious that utilization review is only a crude first step toward evaluating the quality of health services, and is even less useful in the outpatient setting. This problem has led to the actual inspection of the diagnostic and therapeutic processes, usually by a medical panel of peers reviewing clinical records, applying predetermined criteria for selected clinical problems. This goes under the general title of the medical audit.

The clinical entities selected for evaluation are assumed to be indicative of medical practices as a whole, but this has been questioned.[1] If a clinician is shown to manage diabetes well but urinary tract infections poorly, what can be said of his general competence? The "tracer" diseases selected for evaluation are chosen because of certain characteristics. They must have significant functional impact, be well-defined, and have clear criteria for diagnosis and management. The effect of social and other non-medical factors must be understood. The prevalence must be high enough so the evaluation can take place. Finally, the natural history of the disease must be modifiable depending on the level of care administered.

IMPORTANCE OF EVALUATION

While evaluating clinical skills in these highly defined areas is of obvious value, much of the outcome of a practitioner-patient confrontation in outpatient primary care is not significantly influenced either by the presence or absence of such skills. The most frequent single diagnosis in outpatient practice is the self-limited viral upper respiratory infection. This should not be ignored as it makes up a significant portion of the time and cost of primary care.

The emphasis on the diagnosis and management of well-defined nosologic entities such as essential hypertension, fractures of the fore-

arm, and urinary tract infections, entities for which the criteria for diagnosis are widely accepted and for which there is general consensus of appropriate therapy, ignores another facet of the medical care process. Problems difficult to characterize (headache) or possessing no known effective therapy (sickle cell disease, advanced metastatic carcinoma) or a broad range of possibly useful therapies (schizophrenia) are more difficult to evaluate by objective standards, but may precisely be where clinical acumen is most. Furthermore, the record audit has no way of evaluating a clinical problem which was present but went totally undetected.

Beside focusing on only a part of the health service process, the medical audit has certain other faults or inadequacies as a tool to evaluate medical care. The most apparent is that it depends greatly on the quality of the medical record. Records vary tremendously in consistency, format, legibility and completeness. Because they are man-made, they are subject to errors in recording. This makes auditing difficult and potentially inaccurate. The problems-oriented record[2] helps answer some of these questions by providing a systematic listing of problems so the auditor may easily identify them and follow their course. A consistent, uniform, comprehensive retrievable data base on all patients seems essential if record review is to be useful. The volume of information to be scrutinized will ultimately make a computerization scheme indispensible.

Medical auditing is time-consuming, and since professional time is a scarce resource, there is a question about whether data-gathering can be done by non-physicians. With the appropriate training this seems quite likely, and a new category of paramedical person, the record auditor, may be in the making. However, it would still fall to the clinician to make the basic judgments from the information collected.

The medical audit does not look at the quality of care from the patient's point of view. It cannot measure problems that were avoided or overlooked. It often cannot measure the patient's intellectual or emotional response to the therapeutic endeavors, his adherence to treatment regimens, the simultaneous use of other practitioners, flow and continuity of care over several years, the uncomfortably long waiting times or the response to the economic burden. This does not necessarily mean the practitioner is not cognizant of these elements, but merely that they are sometimes not recorded.

The conduct of peer review by medical auditing will produce some unique situations. It is conceivable that severe management errors will be detected during routine auditing, such as the inadvertent prescribing of an excessive dose of a drug. This could place an ethical obligation on the part of the physician-auditor to notify the clinician immediately, and mechanisms for such procedures should be built into the system.

POTENTIAL PARADOX

There seems to be a potential paradox in the auditing of clinical conditions with defined, consensus diagnostic and therapeutic measures. If the consensus is so strong, why leave it to the memory of the practitioner to recall each measure? Should not standard forms or checklists be provided for each diagnosis, and let the clinician either fulfill the measures or have a reason not to? This would seem to be much more efficient.

If record auditing neglects the patient's viewpoint, then it most certainly neglects the perspective of the community setting from whence he came. As the family physician becomes more concerned with the community milieu and the genesis of health problems, the clinical record is of less help. Particularly neglected are preventive, screening, and other public health programs, and the patient's physical and social environment. Of course, the clinical record probably never was intended to be a document of community health problems, but it indicates the need for supplementary health information sources, probably taking the form of various health surveys.

The type of information collected may be divided into the three elements of medical care: structure, process, and outcome.[3] The former is easier to measure than the latter but ultimately less useful. Structural measures include the number of clinics, hospital beds, physicians or therapists in a community; the availability of special referrals, doctor-patient ratios, the average distance or average driving

time to the nearest physician, and the capability of the x-ray equipment.

This is necessarily the first step in looking at care. These data again are the easiest to obtain but least indicative of the health service quality rendered. Structural measures may also be of an administrative nature, e.g., cost efficiency of billing procedures or average waiting time for an emergency or routine problem.

A different view comes from examining the process of health services. Examples include number of patients seen per day, amounts of various drugs prescribed, how many different family physicians did the average patient see in a year (a measure of care continuity). Was an intravenous pyelogram ordered in the evaluation of hypertension? Was the stool cultured in the diarrhea patient? Did the diabetic patient receive competent dietary counselling? Were follow-up visit appointments kept? Some of this can be gleaned from the medical record, but other means of data collection are needed, particularly survey techniques. Process measures seem to be closer to the desired evaluative goals, and in practice are most frequently measured.

Theoretically, however, outcome measures would be most useful. Did the care delivered enhance the patient's health? For several reasons this is extremely difficult to determine. As stated earlier, many problems presented are self-limited and resolve spontaneously. Yet, temporary symptomatic relief is important to patients. (The two most commonly prescribed drug categories are tranquilizers and analgesics.) Other problems have an unmodifiable natural history. Mortality statistics are often not useful, particularly in the short run, because most out-patient care is not concerned with potentially fatal problems. Furthermore, prolonging life is not always a primary health goal and in some circumstances not a goal at all. Many drugs and therapeutic techniques have never been systematically evaluated in terms of patient longevity. (Do diuretics for ankle edema due to venous insufficiency prolong survival?) Because of this dilemma, short term outcomes are more useful. Examples include the percent nonunion of pinned femoral head fractures, percent resolution of acute dermatitis within two weeks, percent recurrence at herniorrhaphy site or the percent successful control of hypertension or bacilluria. There are many clinical entities which may be evaluated in a short term setting, but the endpoint, whether objective or subjective, must be measurable.

In general, the medical audit in its present state is probably more useful to evaluate various forms of health care organization (e.g., "solo" versus "group" practice) rather than an individual practitioner. In the latter instance standards of comparison are difficult to obtain and unique problems arise. Can a physician who is the only and over-burdened resource in an isolated area be judged by the same criteria as others who are less stressed? The conditions in which care is delivered is crucial to know in any evaluation scheme.

There are other parameters to measure a practitioner's performance, such as his efficiency. Is he spending too much time on unimportant complaints? Is he ordering too many laboratory tests? Does the diagnostic work-up flow smoothly?

Other skills potentially measurable are thoroughness, reliability, ability to analyze and synthesize important clinical problems, and patient communication skills. These require rather sophisticated measuring instruments which will require many resources. But more importantly, these should not be measured unless there are resources available which can be shown to improve deficits found. There is no point to pragmatic evaluation of deficits if remedies such as continuing education programs do not exist. It is probably best when establishing standards for individual practitioners that only the grossest errors should be sought until the methodology for evaluation is improved.

Evaluation programs may have unpredicted benefits. The most productive effect at the present time may be in the conduct rather than the results of evaluation. Practitioners are forced to step back and look at their activities, as they have not done previously, and it may serve as an effective teaching instrument or at very least a stimulus to more effective continuing education programs. Involvement and subsequent education of consumers at some level in the program may also suggest alternatives to malpractice suits as a means of controlling and rectifying errors in medical practice.

The following guidelines may be helpful to

physicians interested in establishing an evaluation program of out-patient care:

1. Provisions should be made to protect the confidentiality of clinical information obtained.
2. Know what monetary and personnel resources are available before starting.
3. Seek statistical aid in managing and tabulation of acquired data.
4. Choosing a comparison group for any measures taken is difficult. Sources may include other practitioners or health teams, the same practitioner over time, other comparable health centers, or medical literature results.
5. Be careful not to set up clinical trials to evaluate specific drugs or other therapies themselves unless that is what you wish to do. The methodology is much more difficult and resource needs greater.
6. All evaluative techniques need not be objective. Patient comfort and attitudes are quite useful, as are structured grievance procedures.
7. Use information derived as educational devices for all practitioners concerned.
8. Review diagnostic and management standards frequently as they change quite often.
9. Try to achieve measures of the physical, social and environmental health of the community as a whole, not merely those receiving one individual's or group's services.
10. Practitioners should know in advance who and what is being measured. They should all know the rules before the game starts, and will then be much more likely to participate.

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3. Donabedian, A.: Evaluating quality of medical care. Milbank Memorial Fund Quarterly, **64**:166-203.

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The author has prepared an introductory bibliography for those interested in measures to assess outpatient care in their own setting. This bibliography may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

CONTINUING EDUCATION

Between July 1, 1971 and June 30, 1972 The University of Iowa College of Medicine presented 110 continuing education programs in 12 different Iowa counties. These activities involved 4,914 registrations and 1,025 faculty participations. In addition, a great amount of continuing education is accomplished via:

- services provided to patients and communicated to local physicians,
- tens of thousands of telephone calls to faculty members annually,
- guest speaker activities,
- individualized educational consultation with the Office of Continuing Medical Education,
- and by these additional outreach programs involving students: MECO, Preceptorship Program, and Externships.

As interest and need for continuing medical education grow, there is increasing need for more activities to occur on an individualized basis, and in community hospitals. The Office of Continuing Medical Education stands ready to help individuals and groups on request.

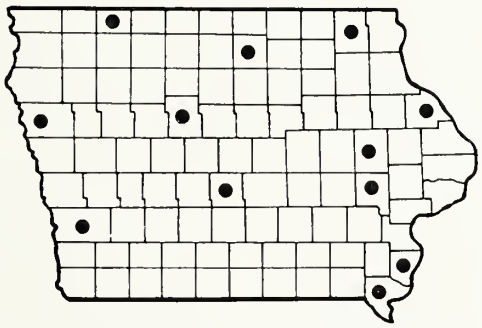


Figure 1. One hundred ten continuing education programs were offered by The U. of I. College of Medicine in the above noted counties during the 1971-72 academic year.

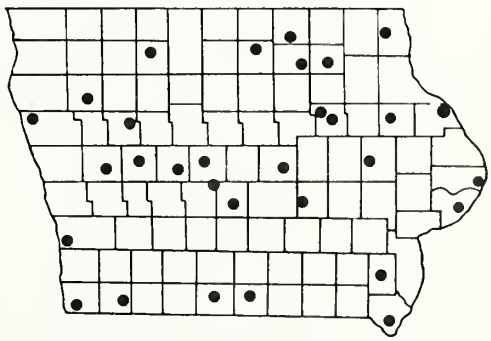


Figure 2. Forty-seven U. of I. medical students spent the summer of 1971 in 31 Iowa communities as shown above. This experience was arranged through the MECO program.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

UNIVERSITY ISSUE

Spring has just arrived, and each year at this time it is customary for the JOURNAL to recognize the University of Iowa College of Medicine. In presenting this University issue, we extend our thanks to the medical faculty for the contribution of scientific papers throughout the year. Our man on campus, Dr. Richard Caplan, serves in a most capable fashion to encourage the submission of papers. He additionally contributes his own thoughts each month in the Educationally Speaking section of the JOURNAL. The continuing education programs fostered by the College serve all the physicians of Iowa. We are grateful for every one of these contributions.—M.E.A.

TOGETHERNESS

Do you feel dissatisfied, insecure, frustrated or unhappy with your practice of medicine, doctor? Do your principles of freedom and the strength of conviction in the determination of your patients' care seem threatened? Are you becoming tired of being berated and blamed for all the ills of the nation's health-care system?

A recent letter-to-the-editor criticized the medical profession for wanting its organization to stand up for its rights, and went on to belittle the profession for owning large automobiles and traveling widely. Many people drive Cadillacs, and certainly all country club members are not physicians. When will the public realize physicians are no different from insurance executives, newspaper editors, lawyers, labor union executives, doctors of divinity, and other professional people in desiring to reap the benefits of their labors?

People apparently do not resent paying $500 for a color-television set, or $1,500 for a snowmobile (plus 8 per cent interest on the money borrowed to purchase it), but they resent having to pay for health. Some people seemingly do not want good health. They still drink to excess; willingly take L.S.D. and other drugs; smoke cigarettes until their lungs are cancerous; and go out onto the highways and drive in an irresponsible manner. But to pay for an operation or to be cured of meningitis is somehow resented or characterized as excessive.

I have not seen any letters-to-the-editor critical of the cost of automobile repairs after involvement in an unwanted accident, or the high percentage contingency fee of a lawyer in a personal injury lawsuit, etc. Why don't those who write of the physicians' incomes ever mention the sleepless nights, the long tedious days, the no double-time-for-overtime Sundays and holidays, the need for continuing education, and the mental anguish in seeing a child die when nothing can be done?

Now, the government also says we earn too much. Our landlords can raise the rent, our employees can expect 5.5 per cent salary increases, malpractice insurance rates can increase to seemingly unlimited amounts, but we are limited to 2.5 per cent if we can show a decline in the profit margin. Food prices con-

tinue to rise, the price of other commodities goes up and up, and we work longer and under more undesirable conditions with no equitable return.

What can be done about our professional status in the eyes of the public and the government, as well as among our colleagues? Togetherness seems strongly indicated. We must work together as a team; we must educate the public to see our side of the picture; we must continue to provide good medical care in such a way as to be above reproach; we must discipline ourselves in our professional and economic relationships with the public.

All this can be done by strengthening our medical organization—our existing medical organizations, by giving our time and talents to the political as well as the scientific aspects of medicine. We cannot accomplish any lasting results by disorganized griping, or by forming splinter-groups filled with resentment and bitter proclamations, or by enlisting organized labor to drive a greater wedge between members of our profession as well as between the profession and the patients.

Physicians are trained in human feelings. To understand human feelings is a fundamental goal of being. It is not possible, obviously, to correct all the ills of health care provisions single-handedly. Again, we must have the togetherness of established organization. The hospital, insurance carriers, the government, the consumers, and all physicians must work together. Now!—M.E.A.

ON RELEASING INFANTS

Tradition decrees low-birth-weight infants remain in the neonatal nursery until they weigh about 2500 gm. Recent studies* have shown it may be desirable, as well as safe, to release these small infants earlier. This will depend upon their physiologic stability and the reliability of the parents. Thus, weight alone becomes a secondary criterion.

Daily hospitalization rates in local newborn nurseries are approximately $35-40. Special-care and intensive-care nursery rates may exceed $100 per day, depending upon the special care required. The study by Dillard and Korones reveals a shortened hospital stay averaging 6.7 days. The reduction in hospital expenses becomes substantial. Furthermore, the decreased hospital stay provides better utilization of existing facilities resulting in more effective nursing care.

Is this a safe practice? Education of the parents can make it safe and desirable. As the infant becomes thermostable and is taking feedings by mouth the mother can be introduced to the daily-care routine in preparation for taking the infant home. The nursing staff can demonstrate techniques of care and at the same time promote better public relations between the hospital and the parents. Yes, the practice can be safe. This study demonstrated no significant effect upon subsequent weight gains or upon rates of rehospitalization or deaths of these small infants. Just as important, also, is the earlier establishment of the mother-child relationship. This relationship is often strained by our emphasis upon the smallness of the infant. It tends to heighten the mother's fear of her inability to provide proper care. We can help immeasurably to give the mother true confidence in herself. The infant will receive better care. The hospital costs to the parents will be reduced. The utilization of hospital facilities will be improved. Only tradition is threatened.—M.E.A.

* Dillard, R. G. and Korones, S. B.: Lower discharge weight and shortened nursery stay for low-birth-weight infants. New Eng. J. Med., 288:131-133, Jan. 18, 1973.

ANNUAL MEETING

The 1973 IMS House of Delegates will meet April 28-30 in Des Moines. Important policies will be established by those physician delegates chosen at the local level. Confer with your delegate(s) if you have a special concern about which you'd like to have him(them) be aware. Remember too sessions of the House are open to all interested IMS members.

LETTERS TO EDITOR APRIL

DEAR EDITOR:

The Marion County Resolution on solving our malpractice dilemma through state legislation, which has been introduced a number of times at IMS annual meetings, has been strongly opposed by the lawyers, and that's the reason we have not progressed with it.

Our resolution on Vexatious Litigation, if implemented with state legislation, would eliminate nearly all nuisance suits, for when a plaintiff realizes that if he loses his nuisance suit, he will not only have to pay court costs but also a reasonable fee to the winning party's attorney (in this case the physician's attorney) his desire to sue evaporates. Also, under our proposed law, the poor man, if he has a justifiable complaint, will be taken care of and provided with a lawyer and the necessary means to sue. The enactment of our proposed state legislation should cut the cost of our insurance premiums by at least 50 percent, if not more.

Last year our Reference Committee on Legislation referred our Marion County resolution to the Medical-Legal Committee for further study. The Medical-Legal Committee asked the defense lawyers about our resolution. After their meeting with the defense attorneys, the Medical-Legal Committee reported, "that altering state statutes in the malpractice area would have limited impact, not nearly commensurate with the effort involved in securing passage—."

Asking the lawyers what they think of our resolution, is like the chickens in the chicken coop asking the fox to take care of them. There is a conflict of interest between medicine and law on anything that eliminates vexatious litigation.

Those who advocate "no fault" legislation for auto owners have the same problem with the legal profession. But the "no fault" legislation proponents don't ask the lawyers what they want. They tell their wants to the state legislators and succeed in the enactment of the "no fault" law.

The doctors must use the same procedure as the "no fault" proponents and tell our legislators the proposed law that we want enacted and work to get it accomplished. The enactment of this proposed law as explained in our 1972 Marion County resolution will solve our malpractice problem, in spite of what the lawyers tell us. This proposed legislation will not only solve the malpractice problem of the physicians, but will also be beneficial to 99 percent of the public.

PETER VAN ZANTE, M.D., *Pella*

EDITOR'S NOTE: The quote from the Medico-Legal Committee noted in the third paragraph of Dr. Van Zante's letter is taken from the Committee's 1972 Handbook Report and is based on deliberations which occurred prior to the introduction of this particular Marion County resolution.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

April 4	Ophtholmology Clinicol Conference
April 9-12	Troining for Physicions in Coronory-Core-Unit Techniques
April 9-12	Echo-Ophtholmogrophy Course ond Workshop
April 19	Renol Diseose Conference (Sioux City)
April 19-21	In-House Conference for Proctitioners
April 24	Renol Diseose Conference (Woterloo)
April 24-25	The High-Risk Obstetricol Potient, Fetus ond Newborn
April 28-29	Dissection Course in Orbitol Anotomy
May 2	Workshop on Quolity Assuronce Progroms in Community Hospitols (St. Luke's Hospitol—Sioux City)
Moy 3	Workshop on Quolity Assuronce Progroms in Community Hospitols (Holidoy Inn—Council Bluffs)
Moy 10-12	Iowo Eye Associotion
May 16-17	Seminor on Principles of Pesticide Epidemiology
May 26-27	Workshop on Quolity Assuronce Progroms in Community Hospitols (Holidoy Inn—Amono)

Unless otherwise specified oll courses and conferences are held at The U. of I. College of Medicine, Iowa City.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

"PROFESSIONAL GOSSIP"

Sometimes it's called informal professional consultation. Sometimes Kaffee Klatsch Konversation, sometimes scuttlebutt, sometimes rumor. "Professional Gossip" is a fresh designation for it, at least to me.

And what is "it" in the last paragraph? "It" refers to continuing medical education accomplished by word of mouth from another physician. "It" is a type of learning by testimony or hearsay. It is on every list of the methods of physician learning, and surely it is of great importance. One major reason why young physicians prefer not to practice in isolated solo settings is their desire and sense of need for the input of know-how and tips which colleagues can usually be trusted to provide.

When we hear an expert speak, or read what he has written, or converse with a colleague or group of them at a meeting, or learn from our own trials and errors, we likewise enjoy passing on the word. Perhaps it's a partial fulfillment of our professional oath, since those who practice *secret* remedies and techniques are usually considered charlatans.

Most such information is provided, accepted and transmitted in good faith. But once in a while we should reflect on how much inaccuracy creeps into this kind of message transmission. Remember in the children's game, "Telephone," the object is to send a message verbally from one player to the next, and note with glee how altered or garbled it is when it finally returns to the sender? Such is the hazard of professional gossip. Of course, we musn't believe everything we see in print, either. Therefore, a certain wariness is appropriate for the practitioner, who must remain alert and analytical, perceptive and probing when getting a morsel of new information from a colleague. Too often we play a "hot tip" at the races or in the market because they sometimes pan out, and indeed there is excitement in playing that way. But the smart man at the track or the market (I hear) generally has or seeks additional information to cross-check the likely accuracy of the hot tip.

To make medical decisions based upon "gossip" would strike most of us as unsatisfactory and surely not something that *I* do. That's because of the unsavory connotation of that word "gossip." But heed the warning, and try to be extra cautious that the learning obtained from informal professional conversation and consultation is more solid and trustworthy than gossip.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

FAMILY PRACTICE TEXT

Robert E. Rakel, M.D., professor and head, Department of Family Practice, The University of Iowa College of Medicine, is one of three editors of a new textbook entitled FAMILY PRACTICE published by W. B. Saunders Company. It is a basic text for students and residents in Family Practice, and may be used also as a reference for practicing physicians. Contributors are physicians in family practice education and private family practitioners. The volume, which exceeds 1,000 pages and costs $33.00, will have a second printing in May.

we can manage the part of your finances that your wife doesn't!

A successful professional person has a serious problem when it comes to managing his investments! Careful attention to detail and a great deal of time are required. But how can he find the time? Either a few minutes must be squeezed into his already tight professional hours or taken at the expense of his leisure. Of course he could turn the job over to his wife. But even if **she** has the time, is it really fair to impose this burden on her . . . or expect her to be an expert?

WE CAN HELP!

Iowa Trust Departments understand the investment needs of professional people. Because taxation can eat up a large part of their income we plan investments to mitigate its effects. We supply the expertise you'll need to build (or preserve) your funds.

With an Investment Management Account or Living Trust you won't be bothered with details! We'll keep the books and give you the information you'll need for your tax return. Best of all, since you can deduct our fee, the actual cost is small! So why not give us a try. What better time than now!

IOWA TRUST DEPARTMENTS CAN SAVE YOU TIME AND MONEY

IOWA TRUST ASSOCIATION
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WHAT DO YOU KNOW ABOUT MEDICREDIT?

QUESTION OF THE MONTH: *Keen interest in national systems of health care financing is and has been apparent among which of the following: ( ) The Federal Administration, ( ) Legislators, ( ) Economists, ( ) Insurance Experts, ( ) Labor Leaders, ( ) Physicians, ( ) None of the Preceding, ( ) All of the Preceding.*

Give yourself an "A" if you checked the last box. Easiest test I ever took, you're thinking. Probably so. But how much do you know about the various health care financing proposals now being considered? Only a little?

We'd like to describe the main features of one major national health insurance proposal now before Congress. This particular measure has the sponsorship of 157 Congressmen. Iowa lawmakers among the sponsors are Representatives H. R. Gross, Wiley Mayne and William Scherle.

MEDICREDIT

Official title for this proposal is "Health Care Insurance Act of 1973." It's more commonly called "Medicredit." And its originator and main advocate is the American Medical Association. Bear in mind that better than 2,100 Iowa medical doctors are AMA members.

Without disturbing the Medicare program for the elderly, but replacing Medicaid for the poor and near-poor, Medicredit makes available to those under 65 a private program of comprehensive medical and health care protection, covering both ordinary and catastrophic expenses of an illness or accident.

Under Medicredit the protection desired may be elected by the individual or family, i.e.: (1) a health insurance policy from a company; (2) membership in a prepayment plan such as Blue Cross-Blue Shield; or (3) membership in a prepaid group practice plan (where the patient pays a fixed fee per month or year and receives medical and health care as needed). The several options available under Medicredit would have to be approved by the respective states to assure the benefits meet national standards.

For low income persons unable to buy protection for themselves and their dependents, the federal government would pay the total premium or membership cost. For persons whose income is higher, the federal contribution would follow a specified sliding scale. As income rises, the federal share would drop.

BASIC COVERAGE

Medicredit's approved protection anticipates two classifications: basic and catastrophic. In the basic category inpatient hospital or skilled nursing care facility coverage is afforded for 60 days during a 12-month policy period. Within the 60-day limit, two days in a skilled nursing care facility would count as only one day. The inpatient services cover all care customarily provided in either type of facility. Also provided under Medicredit are the outpatient services provided in a hospital emergency room; home health care; and ambulance service.

The Medicredit basic policy or plan would also cover expenses of all medical services—

IN THE PUBLIC INTEREST

Iowa
a place to grow

preventive, diagnostic of therapeutic—provided or ordered by a doctor of medicine or doctor of osteopathy, whether in a hospital, a skilled nursing care facility, the physician's office, the patient's home or elsewhere.

These medical services would include diagnosis or treatment of illness or injury; psychiatric care; well-baby care; inoculations and immunizations of infants and adults; physical examination; diagnostic X-ray and laboratory services; radiation therapy; consultation; services for pregnancy and its complications; and anesthesiology.

CATASTROPHIC COVERAGE

After the 60 days of hospital services under the basic component, coverage of hospital expenses would continue and switch to the catastrophic category. Medicredit would thus provide unlimited protection for hospital costs. Physician services, emergency and outpatient services, and home health services are unaffected as they continue without limit under the basic coverage provisions.

It is the intention of Medicredit to give maximum help to those who need it most, and minimum help to those who are best able to pay their own way. Financial condition is determined solely by the amount of federal income tax a person or family pays whether by withholding or direct payment when the individual files his tax return.

THE COSTS

If a person or family owes no federal income tax for the year—whether because of no income, low income or number of dependents—the total cost of the basic and catastrophic coverage is paid by the federal government. The family would qualify to receive a "certificate of entitlement" to cover the entire premium or membership cost for an approved program from whatever insurance company or plan the family chooses.

For families or individuals who pay federal income tax, the formula is more complicated. The cost of the approved policy or plan would divide into two parts. Most is for the basic coverage; a smaller portion is for catastrophic coverage. The federal government would pay the entire catastrophic cost for everyone. It would pay a percentage of the cost of basic coverage according to the amount of income tax the family or person owes.

For example, a man with a wife and two children who makes $8,000 a year, taking standard deductions, would owe $573 in income taxes. This figure would put him in the 42% Medicredit category. Assume then that an approved program for the family cost $700, of which $650 was for basic coverage and $50 was for catastrophic. His Medicredit benefit would be 100% of the catastrophic premium plus 42% of the basic premium. He would thus pay $377 and the government would pay $323 in his behalf for the "certificate of entitlement." Or if he wished, he could subtract the $377 from the income tax he owes and pay $700 for his health care coverage.

DEDUCTIBLES

Any insurance policy, prepayment plan or membership group offering as many benefits as those offered by Medicredit's approved programs would require financial safeguards. The safeguards nearly always take the form of deductibles (or "co-insurance")—amounts the patients pays before the program itself begins to meet expenses. Deductibles keep a program's total cost lower and prevent abuse or over-use by patients or physicians.

Basic Medicredit benefits would be subject to a $50 deductible per hospital stay; and 20% co-payment on the first $500 of expenses of the family for each of the following three categories: (1) medical and surgical care; (2) emergency room, outpatient, and home health care; and (3) dental care.

Catastrophic benefits are subject to a deductible based on the family's taxable income, that is, income remaining after all tax deductions and personal exemptions. The catastrophic deductible is 10% of taxable income, reduced by any deductibles and co-payments paid by the family toward its basic benefits.

TOTAL COSTS

The low and high cost estimates to the government for Medicredit have ranged from $8 billion to $17 billion. The taxpayer cost for the other proposed national programs has been estimated from $40 billion to $77 billion.

Medicredit is an option which minimizes red tape, maximizes private initiative and action and offers supplementary assistance from the government. It is an alternative which deserves careful consideration by the federal lawmakers and the others in our *Question of the Month.*

Doctor's Business

by LARRY E. LEAVERTON

THE IMPACT OF TAXES

Around April 15, when settlement of personal Federal, State, Self Employment, and property taxes are due, the question we all ask is—"Where did the income go?"

In answering this question, if you have no complete accounting of your finances, the copy of your Federal tax return is a good place to start. Line 17 shows your adjusted gross income, which is your net professional income plus nonprofessional income such as interest, dividends, and capital gains. From this adjusted gross income, the first big items to subtract are Federal, State, and local taxes. The remainder is your spendable income for personal living expenses, charities, your insurance program, payments on notes and mortgages, and investment. Included in this "investment" figure would be investment in new office equipment or in a medical building. This is felt particularly by the new physician.

How your spendable income is apportioned is easier to control than the taxes. As your income increases your income taxes increase in greater proportion. Some think when they are in, for example, a 45% Federal tax bracket they are paying 45% of their income in Federal tax. This is not true, as the tax is scaled upwards in brackets from 15% all the way up to the 45%. For example, a married taxpayer with a net taxable income of $40,000 pays about $10,340 in Federal tax—about 26%. It is just the top 4,000 that is taxed at 45%. In Iowa tax, he would pay $362.50 plus 7% of all Iowa net taxable income over $9,000.

Studies by our firm show the average physician will spend about 25% to 30% of his net income for Federal taxes, 48% for personal living expenses, about 5% for life insurance premiums and about 17% to 22% will remain for liquidation of his notes and mortgages and for investment. We refer to this latter amount as Net Gain for the year, or the amount by which your Net Worth has increased. Doctors participating in a Self Employed Retirement Plan or a Corporate Profit Sharing or Pension Plan must remember their net income is reduced by their contribution to the tax-deferred Plan so this amount in effect, adds to their Net Gain and Net Worth.

If your Net Worth is not increasing, corrective measures should be taken. It is important to set financial goals while there is still time. The financial strain some doctors face starts during the period of his education. Unless he receives gifts from relatives or other assistance he must borrow money. When he starts practice, equipment must be purchased. If he joins an established medical group he is expected to make an investment. He is establishing and furnishing his first permanent home. His family, denied many items during his training, is eager to use whatever credit is available to purchase furniture, appliances and automobiles. The result is often over-extension of credit and overspending.

The doctor with his personal financial affairs in order will have his taxes budgeted and on a current basis. He will take all prudent steps to minimize his taxes. Minimizing taxes does not mean investing in highly speculative ventures just to get tax losses. There is little economic justification in ignoring basic investment values and adopting the premise that losses are profitable. He will have set realistic financial goals. He will have an adequate insurance program to protect himself and his family from untimely death or disability. He will have an up to date estate plan with the counsel of his attorney, trust officer and financial advisors to minimize shrinkage of his estate by taxes and other costs. He will follow a retirement plan.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

Morbidity Report for February, 1973

Diseases	Feb. 1973	1973 to Date	1972 to Date	Most February Cases Reported From These Counties
Chickenpox	2169	4118	2421	Scattered
Conjunctivitis	83	136	88	Appanoose, Linn, Plymouth
Erythema infectiosum	210	227		Delaware, Iowa, Wright
German measles	37	76	120	Scattered
Gastrointestinal viral infection	1582	2979	2347	Dubuque, Johnson, Lee
Impetigo	48	86	105	Scattered
Hepatitis, infectious	14	34	45	Carroll, Polk
serum	7	10	2	Johnson, Polk
Infectious mononucleosis	76	151	161	Johnson
Influenza, laboratory confirmed	35	51	63	Fayette, Johnson
Influenza-like illness	4127	6339		Scattered
Measles	44	97	190	Cerro Gordo, Hancock, Linn
Mumps	600	1049	2229	Scattered
Pediculosis	19	36		Cerro Gordo, Linn
Pneumonia	146	295	208	Buena Vista, Scott, Johnson, Pottawattamie
Rabies in animals	19	43	38	Scattered
Rheumatic fever	3	5	7	Pottawattamie, Scott, Wayne
Ringworm, body	18	28	26	Appanoose, Jones
Streptococcal infections	876	1381		Scattered
Tuberculosis, active	14	24	17	Polk, Woodbury
Whooping cough	0	2	11	
Eaton's agent infection	2	5	0	Johnson, Warren
Encephalitis, associated with				
mumps	3	3		Clinton, Johnson, Lee
viral	2	2	1	Scott, Woodbury
type unspecified	5	5		Delaware, Des Moines, Johnson, Page, Wapello
Herpes zoster	1	1	0	Johnson
Meningitis, viral	1	3	1	Hancock
type unspecified	6	6	3	
Pericarditis	1	1		Johnson
Scabies	1	1		Story
Giardia lamblia	4	4		Johnson, Polk
Ascariasis	1	1		Hamilton
Cylomegalovirus infection	1	1		Black Hawk
E. nana amebiasis	1	1		Dubuque
Salmonellosis				
S. heidelberg	1	4	1	Polk
S. reading	1	1		Black Hawk
S. typhimurium	1	3	5	Linn
type unspecifed	1	1		Plymouth
Shigellosis				
S. sonnei	16	54	44	Linn, Polk
Venereal disease				
gonorrhea	383	846	948	Linn, Polk, Scott
syphilis	22	42	76	Scott

IOWA MEDICAL MISCELLANY

(Continued from page 141)

HEW APPOINTEE . . . Charles Edwards, M.D., who once practiced in Des Moines, has been named the federal government's highest ranking health officer—assistant HEW secretary for health.

OFFER RESEARCH GRANTS . . . The Myasthenia Gravis Foundation, Inc. is offering 10 research fellowships of $1,000 each to medical students for the forthcoming academic year. Additional information is available on request at IMS Headquarters.

FAMILY PRACTICE . . . Continuing to receive Society support is a legislative measure to establish and maintain community family practice residency education programs in Iowa. A state appropriation for this purpose is being sought cooperatively by the IMS, the Iowa Academy of Family Physicians and The University of Iowa College of Medicine. Three Iowa counties have active family practice residency programs and four others have them in the planning stage.

MORE ON FAMILY PRACTICE . . . The percentage of freshman medical students at The University of Iowa designating family practice as their career choice has jumped from 27 per cent in 1966 to 52 per cent in 1972.

About IOWA Physicians

Dr. Clifford Rask, Maquoketa, told the Grace Eventide Guild in DeWitt of his medical missionary work in Africa in a recent talk. . . . **Dr. James O. Stallings,** Des Moines, described "Plastic Surgery in Relation to Cleft Lip and Palate," at recent meeting of Cleft Lip and Palate Group of Central Iowa. . . . Page County Medical Society has elected **Dr. Najed Chaarani,** Shenandoah, its new president. Other officers are **Dr. Jerry Miller,** Clarinda, vice president; **Dr. Kenneth V. Jensen,** Clarinda, secretary-treasurer; Dr. Miller and **Dr. Kenneth Gee,** Shenandoah, are program chairmen. Dr. Gee was also named delegate and **Dr. Willard Kuehn,** of Clarinda, alternate delegate, to IMS House of Delegates. . . . **Dr. L. H. Koelling,** Newton, has closed his practice to move to Phoenix, Arizona, where he plans to establish an emergency room or group practice. . . . **Dr. Kiyoshi Furumoto,** Keosauqua, was named recipient of annual Coaches' Award at Van Buren Community School in surprise ceremony during halftime of recent basketball game. Dr. Furumoto was presented letter jacket for his service as team physician. . . .

Board of Directors of Monticello State Bank board has named **Dr. C. G. Thomas,** retired Monticello physician, to honorary board membership. Dr. Thomas is an IMS life member. At recent meeting of Burlington Memorial Hospital medical staff, **Dr. Bernardo Pineda,** was elected president; **Dr. Robert S. Bell,** vice president; and **Dr. George Zimmerman,** secretary. New Executive Council members are **Drs. Gary Smith, Robert Todd** and **Warren Zabloudil.** Dr. Pineda has appointed the following physicians chiefs of service—**Herbert Tjaden,** surgery; **Joseph Stoikovic,** medicine; **Walter Friday,** obstetrics and gynecology; **George Gundrum,** general practice and **Sixto Guiang,** pediatrics. All are Burlington physicians. . . . **Dr. Robert J. Roberts,** assistant professor of pharmacology at U. of I. College of Medicine, is one of four U. S. physicians to receive 1973 Pharmaceutical Manufacturers Association Faculty Development Awards in Clinical Pharmacology. Awards are given annually to young scientists with superior potential who are continuing to develop in productive careers in independent research and teaching in clinical pharmacology. Dr. Roberts is completing training in pediatrics at U. of I. College of Medicine, having previously received M.S., Ph.D., and M.D. degrees at U. of I. He has been appointed assistant professor of pharmacology and pediatrics, effective July, 1973. . . . At recent annual meeting of American Public Health Association in Atlantic City, **Dr. Julius S. Conner,** Des Moines, and **Dr. Kenneth K. Hazlet,** Dubuque, were elected members of Board of Trustees.

Dr. Opas Anolhayanontha will begin family practice of medicine in Traer July 1. Dr. Anolhayanontha is native of Thailand, graduate of Bangkok medical school and interned at Mercy Hospital in Des Moines. He served year's residency in obstetrics and gynecology in Colorado, and four year residency in pathology and hematology in Dayton, Ohio. Dr. Anolhayanontha is now completing his residency in obstetrics and gynecology at Peoria, Illinois. . . . **Dr. Ross G. Randall,** Waterloo, was guest speaker at recent meeting of Black Hawk County Medical Assistants. He discussed ear infection and ear surgery. . . . **Dr. Leonard Lamberty,** Decorah, discussed genetic counseling, amniocentesis, abortion and fetal transplantation at recent meeting of Decorah chapter of American Association of University Women.

Dr. Robert E. Rakel, professor and head of Department of Family Practice at U. of I. College of Medicine, has been elected a director of American Board of Family Practice. Dr. Rakel will fill one-year unexpired term and will then be eligible for subsequent five-year term. . . . **Dr. Patricia Ehrich** will begin family practice in Grundy Center July 1. A 1972 graduate of U. of I. College of Medicine, Dr. Ehrich is completing family practice internship at Broadlawns Polk County Hospital in Des Moines. . . . Special guests of **Dr. Rafael A. Roure** at recent dedication of new Roure Clinic in Glenwood were Governor Robert Ray, U. S. Representative William Scherle, State Representative Calvin Hultman, U. S. Marshal Harold Grindle and John MacDonald, state Republican party chairman. New facility has 11 examining rooms, central lab, small surgery room, complete X-ray facilities, an electrocardiogram room and physical therapy facilities. A native of Puerto Rico, Dr. Roure came to Glenwood in 1963 and later purchased practices of **Dr. M. L. Sheffel** in Malvern and **Dr. Ward DeYoung** in Glenwood. Dr. Roure is assisted by Council Bluffs surgeon, **Dr. Fernando J. Rivera.**

Dr. James T. Worrell, Keosauqua, is new vice chairman of Van Buren County Health Planning Council. . . . **Dr. J. S. LePoidevin,** Waterloo, was guest speaker at recent meeting of Association of Operating Room Nurses of Northeast Iowa. His topic was the battered child. . . . **Dr. Joseph Spearing,** Harlan, was recently named "Man of the Year," at annual award banquet of Harlan Chamber of Commerce. Dr. Spearing was selected for his strong interest in local youth. . . . **Dr. Arthur Ames** is new president and chief of medical staff of Buena Vista County Hospital; **Dr. W. M. Petty,** vice president; **Dr. T. E. Shea,** secretary-treasurer; **Dr. E. C. Laird,** chief of medical service; **Dr. R. H. Mailliard,** chief of obstetrical service and **Dr. R. R. Hansen,** chief of surgical service. All are Storm Lake physicians.

Dr. Owen Frank, Maquoketa, recently delivered his own great-grandchild. The baby girl born January 30 missed her great-grandfather's birthday by one day. Dr. Frank, a Maquoketa practitioner for over 50 years, was 79 February 1. . . . **Dr. Herbert E. Gude,** Iowa Falls, recently received an award from the

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Iowa Falls mayor for leadership provided in an Emergency Medical Technical Ambulance Course. . . . **Dr. Kenneth Gee** and **Dr. Floyd Jones** have re-opened the Shenandoah Medical Clinic and have purchased the interests of **Drs. Harold Henstorf, George Powers** and **J. R. Eisenach.** The building has been vacant since 1970. Dr. Gee was formerly associated with the physician owners of clinic building. Dr. Henstorf is now with Department of Radiology at University of Missouri, Columbia, Missouri; Dr. Powers is resident in psychiatry at Phoenix, Arizona and Dr. Eisenach is associated with Clarkson Hospital in Omaha, Nebraska. . . . **Dr. R. Scott Cairns,** Dubuque, became a Fellow of American Academy of Orthopaedic Surgeons at group's annual meeting in Las Vegas. . . . **Dr. J. C. Timmerman,** Iowa City, was guest speaker at recent meeting of Christian Nurses Association in Kalona. Dr. Timmerman's topic was "Allergy Disorders."

Dr. J. C. Comstock, Calhoun County Medical Examiner, explained duties of medical examiner at recent monthly meeting of Carroll L.P.N. Unit. . . . **Dr. D. A. Dutton,** Van Horne physician for 37 years, was recently named "Outstanding Citizen of the Year," by the Van Horne Community Club. . . . The following physicians—**Dr. Robert L. Cozine,** Emmetsburg; **Dr. R. J. Coble,** Lake Park, and **Dr. M. W. Kirlin,** Spirit Lake, were instructors at recent three-day seminar in Spirit Lake for supervisory personnel of Iowa Highway Patrol. Seminar was sponsored by Iowa Lakes Community College and Iowa State Department of Health. . . . **Dr. James C. Hunt,** chairman, Department of Nephrology at Mayo Clinic, was guest speaker at monthly scientific meeting of Wright County Medical Society. Dr. Hunt discussed hypertension and treatment. . . . **Dr. David A. Rater** has joined **Drs. J. Stuart McQuiston, Richard M. Quetsch, Whealen M. Koontz,** and **James Hood** at Medical Associates in Cedar Rapids to practice internal medicine and cardiology. A 1964 U. of I. medical graduate, Dr. Rater interned at Wayne County General Hospital in Eloise, Michigan. He's had a residency in internal medicine and cardiology at University of Kansas Medical Center. He formerly taught at the Department of Internal Medicine at University of Kansas Medical Center. He is certified by American Board of Internal Medicine.

A NEW CAREER—PSYCHIATRY

Many outstanding Family Practitioners find during a successful career their needs and interests change and their family's needs change—so consider a second career in psychiatry. Our residency training program is a small, truly eclectic, university based program in Omaha connected with University of Nebraska College of Medicine. We balance a carefully planned core curriculum with flexible electives in the best tradition of modern psychiatric education. Our faculty is particularly interested in Family Practitioners. Those who have entered our program in the past have made excellent residents and gone on to a successful career in psychiatry. In many cases, Doctor, the needs of psychiatry can best be met by a return to the same region where you practiced—in a new career. A generous salary schedule is available that will provide for you and your family during three years of training. A few positions are still available at the Nebraska Psychiatric Institute for 1973. Contact us for an interview with one of our Family Practitioners who are now in training. Write Merrill T. Eaton, M.D., Director, Nebraska Psychiatric Institute, or call (402)-541-4600 for further information.

Drs. James H. Walston, Paul A. Fee, and **Lee Van Voorhis,** Sioux City, participated in recent television program entitled, "Profile 9: VD Blues," presented on KCAU-TV. . . . **Dr. Robert Mandsager,** Marshalltown, was mission speaker at recent service of St. Peter Lutheran and Peace Lutheran churches in Monona. Dr. Mandsager served two terms as missionary to Camerouns in Africa and is currently on Board of World Missions of American Lutheran Church. . . . **Dr. Frank Rogers** has been named president of Clinton County Medical Society; **Dr. Robert German,** vice president; and **Dr. L. G. Lauz,** secretary-treasurer. . . . **Dr. H. S. Jacobi,** Waterloo, was guest speaker at recent meeting of Waterloo Unit of Licensed Practical Nurses. Dr. Jacobi spoke on "Abdominal Trauma." . . . **Dr. Ronald K. Bunten** and **Dr. Marshall Flapan,** Des Moines orthopedists, have been named Fellows of American Academy of Orthopaedic Surgeons. At recent meeting of Dallas-Guthrie Medical Society and Auxiliary, **Dr. and Mrs. Wm. Seidler, Jr.,** Jamaica, reported on their trip to New Zealand, Australia and Fiji. While in Melbourne, Australia, Dr. and Mrs. Seidler attend-



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ed World Academy of Family Physicians. Special guests at Dallas-Guthrie meeting were **Dr. and Mrs. R. L. Wicks,** Boone, and Mrs. M. D. Hayden, of Cherokee. Mrs. Wicks is current state president of Auxiliary and Mrs. Hayden is president-elect.

Dr. Franco Chua has opened an office for practice of pediatrics in Marshalltown. Dr. Chua received M.D. degree at University of Philippines Medical School and interned at St. Barnabas Medical Center in New Jersey. He served two years general pediatrics residency at Albert Einstein Complex, New York, and one year at Tulane University, New Orleans. Dr. Chua also completed one year of cardiology training at University of Kansas Medical Center. . . . **Dr. John C. MacQueen,** associate dean, U. of I. College of Medicine, discussed "The Iowa Health Care System and Its Future," at recent Iowa City Conference on this theme. **Dr. Robert C. Hardin,** U. of I. vice president for health affairs, presided at the Conference. . . . Seven Marshalltown physicians have moved into new office complex named Medical and Surgical Associates, Inc. They are—**Drs. Donald Reading, Robert L. Mandsager, Philip R. McFadden, William Wessels, Dennis Draper, John Hughes** and **Carl Lester. Dr. Franco Chua,** who began the practice of pediatrics recently in Marshalltown, will move into the new building soon. . . . **Dr. John Sunderbruch,** Davenport, president, Iowa Foundation for Medical Care, talked about establishment and purpose of Foundation at recent Iowa Hospital Association Conference in Des Moines.

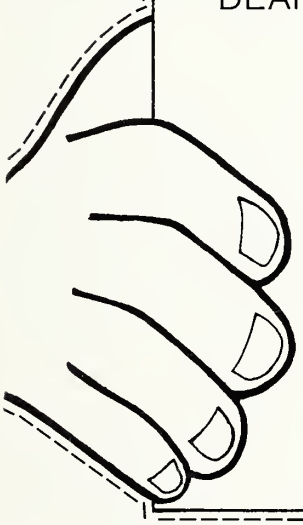
Dr. S. P. Leinbach, Belmond, was guest speaker at recent meeting of Webster City Adult Farmer class. Dr. Leinbach's topic "How to Live With Your Job" was related to the agricultural industry. . . . **Dr. Chester F. McClure** has resigned his position at Northeast Iowa Mental Health Center and has entered private practice in Decorah. Dr. McClure will be located at Winneshiek County Memorial Hospital. He will continue to serve Winneshiek County Home on part-time basis, and assist in development of new Mental Health Center alcoholic program. **Dr. P. R. Hastings,** Waterloo, will replace Dr. McClure at Mental Health Center. **Dr. M. A. Alfridi,** also of Waterloo, will assist Dr. Hastings. . . . **Dr. F. X. Tamisiea,** Missouri Valley, has been named a Fel-

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low in American Academy of Family Practice. . . . **Dr. John Van Tuyl** has joined **Dr. John Banks** in family medical practice at Northwest Medical Center in Cedar Rapids. A 1971 graduate of U. of I. College of Medicine, Dr. Van Tuyl interned in Minneapolis.

The Linn County Medical Society is participating in series of KCRG-TV programs on theme "Health Care Today." **Dr. S. M. Lehr** has represented Linn County Medical Society in planning the series. The programs will focus on new medical facilities and programs in Cedar Rapids. Series is being presented in cooperation with Cedar Rapids' Mercy and St. Luke's Hospitals, where major portions have been filmed. **Dr. Robert A. Sedlacek** served as coordinator for initial program on emergency services, cardiac care and intensive care. Members of Linn County Medical Society participating in first program included **Dr. Montague Lawrence, Dr. Fred Abbo, Dr. Richard Quetsch, Dr. Robert Sedlacek, Dr. Dale Morgan, Dr. Marian Barnes, Dr. William Kettelkamp** and **Dr. Werner Friesen. Dr. Robert Martin,** director of Cedar Rapids' medical education program, will serve as coordinator for second program. **Dr. J. W. Reinertson** will coordinate the April production, and **Dr. W. J. Robb** will supervise the concluding production on orthopaedic surgery.

Dr. Edwin Gilfillan, Bloomfield, retired from active medical practice in February. Dr. Gilfillan, an internist, had been on staff of Gilfillan Clinic since 1951. . . . **Dr. and Mrs. A. J. Havlik,** Tama, attended First International Health Conference in Tel Aviv, Israel. The conference is sponsored by the Weizmann Institute of Science in cooperation with the Tel Aviv University Medical School and the Hebrew University-Hadassah Medical School. . . . **Dr. Adrian E. Flatt,** professor of orthopaedic surgery at U. of I. College of Medicine, has been elected vice-president of American Society for Surgery of Hand. . . . Mrs. Betty Schutter, wife of **Dr. John M. Schutter,** Algona, is Iowa's 1973 Mother of the Year. Dr. and Mrs. Schutter have five children and one grandson. Mrs. Schutter was nominated for the state honor by the Algona branch of the American Association of University Women and the Women's Society of Christian Service of the First United Methodist Church of Algona.

DEATHS

Dr. Robert D. Gauchat, 50, professor of pediatrics at U. of I. College of Medicine, died February 18 at University Hospitals. Dr. Gauchat received M.D. degree at Harvard University in 1951, and completed his pediatric residency at U. of I. College of Medicine. In 1954, he was awarded Helen Hay Whitney Foundation Fellowship in pediatrics. Dr. Gauchat was cited for his research and volunteer work with Distinguished Service Award from Iowa Chapter of Arthritis and Rheumatism Foundation in 1961, and Paul Cotton Memorial Award in 1964. He was co-founder of National Organization for Pediatric History, charter member of Ambulatory Pediatric Association, member of American Association for Advancement of Science, member of Iowa Medical Society and American Medical Association.

Dr. J. Ned Smith, 83, died February 24 at Mercy Hospital in Iowa City. Dr. Smith received the M.D. degree at U. of I. College of Medicine. Following military service during World War I, he returned to Iowa City and practiced general medicine and ophthalmology until his retirement. Dr. Smith was a life member of Iowa Medical Society and American Medical Association.

Dr. E. L. Wurtzer, 84, died February 25 at a Mason City hospital. Dr. Wurtzer received the M.D. degree at University of Illinois in 1912, and completed his internship at St. Barnabus Hospital in Minneapolis. He practiced medicine in Clear Lake from 1920 until his retirement in 1966. Dr. Wurtzer was a life member of the Iowa Medical Society and American Medical Association.

Dr. Donald L. Kyer, 59, psychiatrist and member of faculty of Loras College and Mental Health Center, died February 24 at his home in Dubuque. Dr. Kyer received M.S. degrees from University of New Hampshire and Harvard University and the M.D. degree at Boston University. Before locating in Dubuque, Dr. Kyer was superintendent of Mental Health Institute at Independence. He was a member of American Psychiatric Association; Iowa Medical Society and American Medical Association.

Medical Assistants

by TENORA MEYER, CMA

POMR SYSTEM

Many recent articles and books discuss the "Problem Oriented Medical Record." As medical assistants, we should become familiar with this system. It is a form of record keeping which may extend from hospitals into the outpatient realm for the purpose of continuity.

The problem oriented approach was designed to provide quality data and more comprehensive patient care. The American Medical Record Association has urged medical record professionals to become familiar with and support the system. They listed the following advantages:

(1) Takes all the patient's problems into consideration;

(2) Offers an orderly systematic technique of building a structured data base;

(3) Encourages the student, house officer, and practicing physician to use sound logic in planning patient care;

(4) Allows ease of communication between the physician and other personnel providing patient care;

(5) Enhances continuing education of physicians and others involved in patient care;

(6) Enables efficient retrieval of information from the medical record;

(7) Allows for ease and accuracy in preparation of abstracts of patient data.

ATTEND THE STATE CONVENTION OF MEDICAL ASSISTANTS MAY 4, 5, 6, 1973 at the NEW HOLIDAY INN, downtown Des Moines. The Des Moines Chapter promises all medical assistants a fun-filled weekend. Discussions of current problems in the medical field will be featured by well-known authorities.

The structure of the problem oriented medical record includes the following:

(1) *Data Base:* The initial data collected through history and physical examination, reports of workup and test results. The patient profile and present illness are an important part of any implementation.

(2) *Problem List:* It is numbered and includes all problems identified in the data base —medical, social, psychiatric, as well as dermographic—expressed either as diagnosis, physiologic finding, symptom, abnormal laboratory test, etc. Diagnostic guesses and impressions are not used.

(3) *Plan:* This section includes the development of plans for further diagnosis and management of each problem requiring attention. All plans are begun by recording the problem number and title so people who follow can tell what is to be done for each problem.

(4) *Progress Notes:* Each problem is dealt with individually and identified by problem name and number and divided into the following sections: 1. Subjective data. 2. Objective data. 3. Assessment, interpretation or impression. 4. On-going plan.

The problem list is a separate sheet and includes the following:

It has been suggested that a separate outpatient "self-limiting" problem list be utilized. Such data could be recorded on a supplementary form accompanying the major problem list, thus enabling the physician to enumerate the actual nature of the self-limiting problem and record dates of onset and termination, as well as recurrences. This would include minor problems, such as lacerations, upper respiratory infections, etc., and would prevent the primary list from becoming cluttered with minor problems.

A manual suggested for reading is "The Manual for the Problem Oriented Medical Record" by Drs. Peter Birk and Eugene Furth.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

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possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

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Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

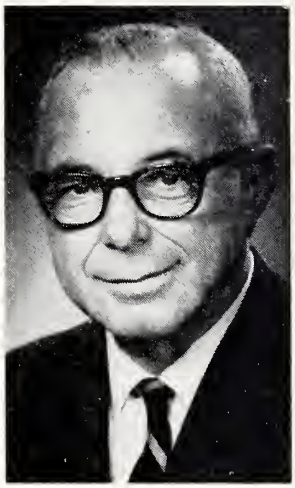
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page



As I write this, the new meeting format for the House of Delegates is awaiting its trial. I am looking forward to the meeting to see if it will serve more effectively both the operational and long-term objectives of the House of Delegates.

I am indeed grateful for the honors bestowed upon me by the Society and will try my best to meet the challenges facing the Iowa Medical Society and medicine in general. Rapid change is occurring in the entire health picture and it is extremely important for all of us to work together to gain as much input as possible into the actions of our various organizations. Constant communication between the various medical organizations, between the University and between the paramedical organizations is necessary if we are to work together to afford the people of Iowa the best of medical care.

It is extremely important for all of you to become involved and participate so we can meet the challenges of society in a coordinated manner. This will enable us to achieve the best of medical care for everyone in the state, and at the same time make sure we all can practice medicine in the best way possible for everyone concerned. Become involved in organized medicine and together we will solve the problems in a constructive manner.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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IOWA Medical Miscellany

PRESIDENT FLOCKS INSTALLED . . . Rubin H. Flocks, M.D., Iowa City, long-time professor and head of the department of urology at The U. of I. College of Medicine, was installed as 1973-74 president of the Iowa Medical Society on April 30. Dr. Flocks succeeds K. E. Lister, M.D., Ottumwa. Named president-elect by the 1973 House of Delegates was Ralph L. Wicks, M.D., Boone. Dr. Wicks has been chairman of the IMS Board of Trustees for the past two years. Other Society officers elected or re-elected by the House were Robert M. Chapman, M.D., Cedar Rapids, vice-president, L. D. Caraway, M.D., Amana, speaker, House of Delegates; R. D. Whinery, M.D., Iowa City, vice-speaker; A. J. Havlik, M.D., Tama, trustee; C. E. Radcliffe, M.D., Iowa City, AMA delegate; J. R. Anderson, M.D., Boone, Erling Larson, Jr., M.D., Davenport, and J. M. Rhodes, Sr., M.D., Pochahontas, alternate delegates; and the following councilors: C. L. Kelly, Jr., M.D., Charles City; D. M. Youngblade, M.D., Sioux City; C. H. Denser, Jr., M.D., Des Moines; A. M. Dolan, M.D., Waterloo, and Hormoz Rassekh, M.D., Council Bluffs.

SOCIETY AWARDS . . . Elmer M. Smith, M.D., Des Moines, is the Society's 1973 Merit Award Winner. Announcement of his selection was made at the House of Delegates' Banquet April 29. Dr. Smith has served as an IMS delegate to the American Medical Association for nine years. Dr. Smith was a family practitioner in Eagle Grove before taking a medical administration position in government in 1964. He is now Director, Bureau of Medical Services, State Department of Social Services. Mr. Ronald V. Saf, Des Moines, is the 1973 recipient of the John F. Sanford award. This recognition is accorded to a layman who has performed meritorious service in the health field. Mr. Saf is the Executive Secretary of the State Board of Medical Examiners and is a member of the Board of Directors of the Scanlon Medical Foundation/Iowa Medical Society. The 1973 winner of the Ben T. Whitaker award is Carroll B. Larson, M.D., professor and head of the department of orthopaedic surgery at The U. of I. College of Medicine. This award is given by the Interstate Postgraduate Medical Association of North America.

CITE HPCI . . . Special recognition was accorded the Health Planning Council of Iowa at April 29 House of Delegates' Banquet. HPCI concluded its work earlier this year after seven years' service as a private voluntary planning agency in Iowa. James Stewart, HPCI executive director since 1970, accepted the commendation.

IRMP PHASE OUT . . . Federal cutbacks will cause cessation of the Iowa Regional Medical Program by June 30. Possibility exists that some RMP projects may extend to February 15, 1974.

EPILEPTIC DRIVERS . . . Under new ruling State Department of Public Safety will not license an epileptic until he has been seizure-free for one year and then only upon receipt of a satisfactory medical report from a physician. A two-year seizure-free period was previously required. The medical report must be on a departmental form.

ALCOHOLISM PROJECT . . . IMS Committee on Alcoholism met April 19 to determine level of youth participation under medical auspices in the June 11-16 Northwest Iowa School on Chemical Substances and Other Addictions. IMS is a co-sponsor. County medical societies have been invited to sponsor a local student.

(Continued on page 227)

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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Postmaster, send form 3579 to the above address.

The Question Box



by DONOVAN F. WARD, M.D.

Dr. Ward is one of two Iowa physicians to serve as president of the American Medical Association. He practices surgery in Dubuque.

What's your assessment of the nation's medical care delivery picture?

We must realize there is a changing pattern in the delivery of health care in the United States due to (1) increased demand for medical services and (2) the tremendous changes in our medical knowledge and technology. Factors entering into this include the increase in population, the tendency for people to migrate to urban areas resulting in a concentration of medical manpower in these areas, the added influx of Medicare and Medicaid patients and the rapid growth of private insurance coverage.

With the ever-increasing numbers of medical graduates and the full utilization of health manpower, it will still be impossible to reach the utopian goal of service to every village and hamlet across this country.

Medicare was the key issue during your 1964-65 AMA presidency. What reactions do you have after approximately 8 years of Medicare?

This question, if completed in detail, would take more space than allotted, but suffice it to say the statements we made in opposition to Medicare were prophetic. To recap without elaboration, Medicare, to begin with, was and is a badly designed and costly law, making it more of a hardship for the elderly with many disillusionments as the result of confusion and many changes in the law. The increase in the rate of deductibles and the rising costs of coverage leave about 45% of all the medical costs of the older people uncovered.

We said there would be over-utilization in spite of full cooperation of the medical profession and more demands made on an already-overtaxed profession. Administrative costs have steadily risen with seemingly less benefits to the recipient—more costly than stated by government officials.

It further requires the physician to spend more time in the political arena to fight for and maintain his rights to practice in a free enterprise system, protecting the ultimate aim of service to needy humans.

As a last measure, we said there would be increasing demand by politicians rather than the people for a system of compulsory national health insurance. I hope those of you who read this will recall and weigh these statements in the present light of activity.

With a note of caution, President Nixon reiterated what we have said many times over in his recent message to Congress, "The dramatic gains in health and medical care have come primarily through private medicine, not from federally-operated systems."

Medicredit embodies principles of Eldercare, the profession's earlier alternative to Medicare. Do you believe Medicredit is worthy of enactment? What are its chances?

Medicredit, including the catastrophic feature, is the more realistic approach to the question of medical care today. It is based upon the ability of the individual to pay, with the government assuming the full payment for those in need from 10% to 100% coverage, based on income tax returns.

Every physician should familiarize himself with the benefits of this proposed plan of the AMA and should use every effort to enlighten the public as to its completeness—urge the representatives in the Congress and Senate to act

(Please turn to page 205)

Summary of IMS Group Coverages

Group insurance opportunities available to IMS member physicians have increased in the past two years. Following is a brief description of the several sponsored programs which interested members may obtain through The Prouty Company, the Society's insurance administrator.

GUARANTEED RENEWABLE-ACCIDENT & SICKNESS DISABILITY

Long term protection is afforded the insured under this plan if he is disabled by accident or sickness. Weekly income up to $300 is provided with lifetime accident benefits; sickness benefits are optional: two years, seven years or unlimited to age 65 with two years thereafter to age 72. Coverage is guaranteed renewable to age 70 under special renewal provisions. Benefit waiting periods from one to six months are available with a resulting premium reduction of from 20 to 45 per cent. Additional benefit features include specified indemnities, non-disabling injuries and loss of use of hand(s).

LIFE INSURANCE

Life insurance is available in a guaranteed renewable non-cancellable form with rates guaranteed for the life of the policy. Coverage is provided up to $50,000 with the automatic inclusion of double indemnity and waiver of premium. Dividends are currently ranging from 14 to 18 per cent depending on the age of the policy. The term insurance is convertible at any time to a permanent plan of the physician's choice without evidence of insurability.

OFFICE OVERHEAD EXPENSE DISABILITY

Office overhead expense is a disability insurance which pays fixed expenses of the physician when he is disabled either by accident or illness. Benefits may be elected from $200 per month up to $1,000 with the payment period covering 15 months. Waiting periods of either 14 or 30 days are offered. Benefits are payable directly to the physician for covered office expenses and benefits remain level to age 70. Premiums are tax deductible as a business expense.

INDIVIDUAL—EXCESS MAJOR MEDICAL

This is a true catastrophic coverage providing benefits to $100,000. It begins when basic medical insurance is exhausted. There is no co-insurance inasmuch as the plan pays 100 per cent for eligible expenses for all causes for the family during each benefit period. A family deductible applies to expenses for all causes and for all covered family members, unlike ordinary plans which are based on a per person, per cause arrangement. A room rate of $75 per day is allowed with a surgical schedule of $3,000 ($4,500 if complications occur). A future increase option makes an increase in limits possible regardless of insurability. Coverage is guaranteed renewable for life and premiums do not increase. Family deductibles are $10,000 and $15,000. The Excess Major Medical 65 and Over Plan is available to supplement Medicare.

ADDITIONAL PLANS

Other coverages are available to IMS members, their families and employees. Included is a personal accident insurance. This provides high limits of accidental death and dismemberment coverage (including permanent total disability). Life insurance is offered at low cost to members of the Woman's Auxiliary to the Iowa Medical Society. "Gal Friday" income insurance is available for physician employees. The premiums are a tax deductible expense.

EXTRA-CASH HOSPITAL INCOME

The IMS Executive Council authorized a group in-hospital indemnity insurance plan in 1972. The Prouty Company has advised the charter enrollment period for this coverage will occur this spring. If a sufficient level of insurable applicants is achieved, all members

(Please turn to page 210)

The May Scientific Section Is Devoted Exclusively to Articles Pertaining to One Disease Entity—Cancer. It Is Hoped These Several Discussions Within a Specific Area Will Find Favor and Be of Interest to Readers of the IMS JOURNAL.—THE EDITORS



The Epidemiology of Cancer: Four Perspectives

Editor's Note: This symposium-type presentation has been assembled from material developed for a panel discussion at The University of Iowa College of Medicine. Support for these investigations has come in part from Public Health Service Clinical Cancer Training Grant T12 CA 08084. An introduction to the discussion was presented by Paul Leaverton, Ph.D., professor in the Department of Preventive Medicine and Environmental Health. Dr. Leaverton explains the epidemiologist is interested in determining what characterizes diseased persons in contrast to non-diseased persons in a population. Included here are the age distribution, time distribution, geographic distribution, as well as differences due to sex, race, socio-economic factors and individual living habits. Dr. Leaverton's brief remarks set the stage for reviews of the epidemiology of cancer in four specific areas.

SKIN CANCER

WILLIAM FRITSCH, M.D.

What are your chances of developing skin cancer? What are the chances of your patients developing skin cancer? This is a question you should ask yourself, and one you should ask about your patients. You can do something about preventing this disease for both yourself and your patients. What factors determine the frequency and distribution of skin cancer? This discussion will be limited to basal cell carcinoma, squamous cell carcinoma and actinic keratosis.

Ultraviolet light is the major causative factor for basal cell carcinoma, squamous cell carcinoma and actinic keratosis. How do we know? In the absence of direct experiments on

Dr. Fritsch is an associate professor in the Department of Dermatology at The U. of I. College of Medicine.

people there are several epidemiological bits of evidence. One, these lesions occur on exposed areas. Two, light skin is at much more risk than dark skin. Three, carcinoma and other degenerative changes (solar degenerative changes of the skin) are seen in the same people and the same areas of skin. Four, carcinomas and keratoses are prevalent in outdoor workers. From experiments in mice, carcinogenicity of ultraviolet light in the wavelength range of 290 to 320 millimicrons is well established.

Consider further epidemiological factors. If one inherits fair skin, he will be more susceptible to the effects of ultraviolet light. The incidence of cutaneous carcinomas is increased in albino negroid people. Occupation is important. If one is a farmer, a sailor, or does anything outdoors frequently, even if it is golf or fishing, and especially without a hat, one can eventually have trouble. Geographical considerations are important. Latitude is a factor. The incidence of carcinomas doubles for every southward movement of 260 miles in the United States.

IMPORTANCE OF WEATHER

For the same reason weather is important. Ultraviolet light can penetrate heavy cloud cover. If the atmosphere is humid there is some filtration of ultraviolet light. This and the lack of cloud cover explain why dry desert climates are frequently associated with a high incidence of actinic skin problems. Possibly contributing are dry skin, heat, wind (and more definitely) x-rays or other ionizing radiation. Curiously, the incidence is not strikingly increased in patients with vitiligo. There is a steep increase in the incidence of skin cancer after the age of 55 to 59, and that is because, to a large measure, the carcinogenic effects of ultraviolet light are not reversible; they are cumulative. One sunburn does not produce skin cancer, perhaps not the second or third, but at some point a person begins to get too much. The incidence in men is higher than in women (approximately 2:1 depending on the region for which this data is compiled). Probably, occupational, recreational and demographic factors are responsible for regional variations.

Another fact in cutaneous carcinogenesis is the chemical carcinogen. Exposure probably relates mainly to occupation. Examples are coal tar, mineral oil, food preservatives, arsenic, just to name a few. Ionizing radiation or therapeutic radiation can be a factor in carcinogenesis. An area treated using radiotherapy may later be the site of a carcinoma. A carcinoma might be treated successfully using radiotherapy yet the same area can give rise to a new carcinoma years later. Radiation can pose an occupational hazard for physicians, dentists and certain industrial workers.

Heredity must be considered. Light colored eyes are more important than fair hair to susceptibility of cutaneous carcinoma. People who are easily sunburned are also more likely to develop carcinoma.

There are several genetic disorders in which cutaneous carcinoma occurs. The basal cell nevus syndrome is an autosomal dominant syndrome which leads to small papules on the skin called basal cell nevi; these can become invasive basal cell carcinomas. Xeroderma pigmentosum, a condition in which ultraviolet light causes several types of cutaneous malignancies—basal cell, squamous cell, actinic keratoses, melanomas, even sarcomas, is autosomal recessive. Interestingly, the defect here is thought to be in one enzyme involved in DNA repair after ultraviolet injury.

Some benign skin lesions can contribute to squamous cell and basal cell carcinoma. And in this situation, the squamous cell and basal cell carcinoma is a complication of the prior condition. Chronic ulcers, osteomyelitic sinuses, old burn scars, tertiary syphilis (especially syphilitic glossitis), lupus vulgaris (a type of tuberculosis of the skin), discoid lupus erythematosus and leprosy are some of the disorders which can lead to cutaneous carcinoma.

PRE-MALIGNANT LESIONS

Other lesions are called pre-malignant lesions. You may argue these lesions do not lead to cancer, but they are in fact cancer in a localized form. It is important to recognize these diseases or to be suspicious, since they are easily treated when first seen and since they may share some epidemiologic factors. Leukoplakia, Bowen's disease, erythroplasia of Queyrat, pre-malignant fibroepithelioma of Pinkus and arsenical keratosis are the most common.

PENILE CANCER

DAVID CULP, M.D.

Carcinoma of the penis is a relatively uncommon disease. In the United States it accounts for 1-2% of all malignancies, but its world incidence varies greatly. On the European continent the incidence is approximately 5% while in China it represents almost 20% of all malignancies. Initially, one might suspect that radical differences are responsible for this wide discrepancy, but in those areas where men live under the same individual and general conditions, except for their racial background, the incidence of penile cancer is the same. Likewise, heredity, venereal disease, occupation, exogenous implantation and trauma, once considered etiologic factors, are no longer thought to play a role in the development of penile cancer. Therefore, other factors are more important.

Poor hygiene is probably the largest contributor to cancer of the penis. This factor is particularly important in the uncircumcised. The prophylactic value of infant circumcision is best demonstrated by the extreme rarity of penile cancer in the Jewish male. Regardless of geographic location or physical condition under which he lives, the Jewish male circumcised at birth has an extremely low incidence of penile carcinoma. Indeed, the occurrence of such a lesion is so rare it is generally reported in medical literature.

Another factor in support of prophylactic infant circumcision is the differing incidence of squamous cell carcinoma of the penis in India among the varous groups of males who practice ritual or hygienic circumcision. The Jews and some Christians are circumcised within a few days of birth. The Moslems circumcise their children at puberty, while most Christians and Hindus are never circumcised. Among Indian males circumcised at birth, penile cancer is a rarity. For those circumcised at puberty, an incidence of 5% has been recorded; those who retain foreskins into adult life have a carcinoma incidence of 15% to 18%. This natural experiment indicates the value of infantile circumcision in preventing carcinoma.

However, not all people accept these facts. In recent medical literature objections to routine infantile circumcision have appeared. Nevertheless, in the face of available facts, the burden of providing a better preventive measure falls upon those objecting to circumcision.

The advantage of circumcision is that it removes the closed preputial space in which urine, normal surface secretions and organisms are retained. Smegma, a substance derived by desquamation from epithelial surfaces and bacterial action, has been incriminated as the source of carcinogens responsible for induction of penile cancer. It is the action of *Mycobacterium smegmatus* upon smegma that releases sterols capable of initating a carcinomatous change. Chronic irritation and infection in this moist, urine-bathed space may also play a role in predisposing malignant changes.

STUDY CONDUCTED

A study of smegma in the production of penile cancer was carried out by Plant and Kohn-Speyer.* They used Paris R^3-strain mice in whom no spontaneous cutaneous papillomata or benign tumors had been observed. Horse smegma was applied to exposed surfaces and buried skin tunnels. The smegma was analyzed prior to use for the presence of male or female sex hormones and none was found. Cerumen, a skin product like smegma which has never been known to be associated with carcinoma, was used as a control substance. A thin pulp of either smegma or cerumen was instilled into the buried skin tunnels. Similar material was painted on exposed, shaved skin areas, and in a third group, subcutaneous injections were administered. In all, 400 mice were treated with smegma, 150 in the tunnels, 122 in subcutaneous injections and 88 painted on the skin surface. One hundred fifty mice were treated in a similar manner with cerumen as control. Microscopic sections of skin and inner organs of these mice were examined. In the smegma-treated mice, lung adenomatas occurred 15 times, lymphoid tumors 15 times, mammary carcinoma 21 times and at the local treatment site 4 papillary warts, 2 hornifying squamous cell carcinomas (1 with definite metastases), 1 undifferentiated skin carcinoma

Dr. Culp is professor and vice-chairman of the Department of Urology at The U. of I. College of Medicine.

* Plant and Kohn-Speyer: Science, 105:391, 1947.

and 1 spindle cell carcinoma. In the cerumen-treated mice, lung adenomatas were found 2 times, lymphoid tumors 5 times and mammary carcinoma 3 times. No tumors were found at the local site of cerumen administration. The time interval required for the nonspontaneous tumors to occur was 36-247 days in the case of the warts, 130 days for the sarcoma and 423 days for carcinoma. All local tumors were located in the buried skin tunnels. No tumors occurred following the subcutaneous injection or surface application of smegma.

The carcinogenic factor in smegma has never been identified although chemical analysis reveals that approximately 45% of the dry substance is fat divided among fatty acids, phosphatids, cholesterol and cholesterol esters.

Therefore, the most widely accepted theoretical explanation for the development of penile carcinoma is a combination of the previously discussed factors working jointly to create a favorable environment for its inception within the closed preputial space.

The only other effective prophylactic measure against penile cancer is frequent cleansing of the area. There is adequate past experience to demonstrate that those who observe good hygienic measures, even in the presence of a foreskin, can avoid carcinoma of the penis. But until better mass hygienic measures can be instituted in the general populace, circumcision remains the best prophylactic measure against penile carcinoma.

To be effective, however, circumcision should be performed at birth or during infancy. It must completely expose the coronal area. Incomplete circumcision encourages adhesions or bridging between the glans penis and the shaft, which completely negates the purpose of circumcision by permitting retention of smegma in the coronal sulcus. Furthermore, the protective changes in the epithelium covering a recently exposed adult glans fail to develop as they do on the exposed glans of an infant. Interestingly, areas of epidermoid carcinoma have developed in the scar following adult circumcision for balanitis. However, in these instances the primary disease was probably not just inflammatory but a combination of inflammation and neoplasm.

LUNG CANCER

NICHOLAS ROSSI, M.D.

The incidence of carcinoma of the lung has been increasing at such an alarming rate some consider it as an epidemic. If this were polio, for instance, or some other infectious disease, and it were occurring at such an increasing incidence, everyone would be up in arms. In 1930, 2,500 people in the United States died from carcinoma of the lung. In the 1960's, this has increased to over 60,000. And by 1975 the projections are that well over 70,000 people will die of carcinoma of the lung.

This has brought a lot of stress on the methods of detection of this lesion—a perplexing clinical problem.

The natural history of the disease has been well studied. One of the most interesting papers was a retrospective study by a radiologist named Rigler.* He showed radiographic findings were present in at least 90% of the patients prior to the onset of any significant symptoms. That is, cancers in the lung grow silently and produce symptoms only when they involve some adjacent structure or have extended beyond the lung. The interval between the first x-ray signs and the first symptoms vary, but on the average it was about one year; between the time of a first observation of a shadow until a definite diagnosis was made, two years. Dr. David Miller at the University of Pennsylvania showed that by knowing the doubling time of the tumor, that if one wanted to detect it from the time of its first possible appearance on an x-ray film, one would have to take x-rays at an interval of about 3 to 6 months. Obviously, the yearly chest film would miss many of the lesions that are subsequently proven to be carcinoma.

There are no good means of detection. We cannot rely upon symptoms. Symptoms mean

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* Rigler, L. G.: Natural history of untreated lung cancer. Ann. N. Y. Acad. Sci., 114:755-766, 1964.

a far-advanced state of the lesion, and the size of the lesion does not necessarily correlate with the survival rate. It is no wonder the emphasis has been on any factor which may have an etiological relationship. Epidemiologic studies suggest the biggest factor is smoking. And I think the evidence is mounting.

CIGARETTE SMOKING

Excess deaths in the United States associated with diseases caused by or aggravated by cigarette smoking are estimated to be more than 200,000 per year *(The Facts About Smoking,* Public Health Service Bulletin #1712). About 60,000 are dying of lung cancer at the present time, of which 75% can be *directly related to long standing cigarette smoking (1970 Cancer Facts and Figures,* American Cancer Society). Excess deaths among current cigarette smokers account for one of every three deaths for men between the ages of 35 and 59. For women the comparable figure is one of every 14.

Information on house to house studies analyzed by the National Center for Health Statistics indicates chronic bronchitis and emphysema are twice as common in men smokers and three times as common in women smokers compared to nonsmokers of the same sex. The deaths from these diseases have doubled every five years since 1950, a rate of increase greater than any other cause of death in the U. S. On the basis of the lower rate of chronic illnesses among those who do not smoke, there are 11 million more instances of chronic illness yearly in the U. S. among cigarette smokers than there would be if all people had the same rate of illness as nonsmokers. This means an additional 77 million work days lost per year among smokers than among nonsmokers.

Clinically there is a relationship between the disease, the disability and death caused by cigarette smoking and the duration and the amount of smoking. Men who are light smokers, that is less than 10 cigarettes per day, gave a 22% higher frequency of coronary and atherosclerotic heart disease than those who have never smoked, but among those who have smoked more than two packs a day the frequency of coronary heart disease and atherosclerosis is 100% greater than among those who do not. A 25-year-old man who smokes two packs of cigarettes a day can expect to die on the average eight years sooner than a nonsmoker of the same age. Not only will he die sooner, but he will suffer more disturbances associated with breathing and heart action. Trends indicate teenage cigarette smoking will result in more and earlier respiratory and coronary diseases because people who smoke at an early age inhale more deeply, smoke the cigarettes shorter and smoke more per day.

Many abnormal physiological observations may be related to cigarette smoking, such as an increased demand by the heart muscle for oxygen and other nutrients; a decrease in the availability of oxygen to the heart muscle; increased permeability of the wall of the blood vessels to fatty infiltration; increase in the fatty acids of the blood; increase of viscosity of the blood; changes in blood pressure, heart rate and rhythm; abnormal patterns of micro circulation in the lung; abnormal thermograms of the extremities; increase in the carboxyhemoglobin of the blood; increased abortion rate; increased rate of still births; increased fetal mortality, and increased prematurity to name but a few.

TEENAGE INCREASE

In 1968, 52% of male Americans and 34% females were cigarette smokers. Today, the figure for American males has dropped 10% to 42% and for women has dropped 3% to 31%. This trend would indicate public education has an impact on social habits. However, studies would indicate progress among teenagers is disappointing. A recent Public Health Service-sponsored survey of teenagers indicates smoking has increased 5% between 1968 and 1971. The National Interagency Council was founded in 1964 with 16 member organizations to establish and implement effective anti-smoking education programs. It had a budget of only 2% of the 300 million dollars the tobacco industry spent in 1970 for advertising. Yet, some progress has been made. In 1970 federal legislation banned radio and television advertising as of January 2, 1971 and strengthened the cigarette package warning to read that the Surgeon General has determined cigarette smoking *is* dangerous to your health. Also, since July 1, 1971, the Federal Trade Commission has had a greater hand in the regulation and control of existing cigarette advertising in print media than it has had since 1965.

The anti-smoking campaign is now international in thrust. For the first time the World

Health Organization devoted an entire session of its annual meeting to the health consequences of cigarette smoking. An excellent report entitled *Smoking and Health Programs Around the World* recently prepared by Emiel Corwin of the National Clearing House on Smoking and Health advises intensive smoking campaigns are currently active in at least 25 countries. For example, cigarette advertising is barred on television in England and France and both from radio and television in Argentina, Czechoslovakia, Iceland, Italy, Romania and Switzerland. Cigarette advertising will be eliminated from radio and television in Finland, Ireland and in Canada as soon as present contracts expire. All commercial advertising of cigarettes is banned in Denmark, Norway, Sweden and Russia. In the free world the approach has been that of education. The approach has been slightly different in the Iron Curtain countries. In Bulgaria—if you wish to smoke while working—you must get permission in writing from fellow workers. Many of the factories in the satellite countries have a ban on smoking during working hours with the "agreement" of the workers, most of whom are smokers.

CERVICAL CANCER

HERBERT J. BUCHSBAUM, M.D.

Interest in the epidemiology of cervical cancer is not new. As early as 1849, an Italian physician noted the rarity of this disease among nuns and the high incidence among prostitutes, and suggested a correlation between sexual activity and cervical carcinoma.

There is no evidence to suggest a hereditary or familial component to cervical carcinoma, nor is there any correlation with hormone status or menstrual irregularities. A recent investigation in two independent areas, epidemiology and virology, has brought us a long way toward understanding the epidemiology of cervical cancer. The incidence varies with geographic location, being high in South America and parts of Africa and Asia, low in Israel, Australia and New Zealand. The frequency does not necessarily follow political borders but may follow ethnic and economic lines. Women residing in cities with high population densities and industrial environments are at greater risk than women living in rural areas. In Iowa, the risk of a woman developing cervical carcinoma is 46.8 per 100,000 in urban areas compared with 26.4 per 100,000 population in rural areas. Further ethnic differences are evident: cervical carcinoma is more common among black and Puerto Rican than among white women, far less common among Jewish than non-Jewish women.

Cervical carcinoma is rare in celibate women, more common in multiparous than nulliparous women, and six times more common among prostitutes. With this evidence suggesting a correlation between coitus and cervical carcinoma, epidemiologic studies have been undertaken. The first question to be answered was which of the multiple factors involved in coitus played the greatest role. Was it the physical act with trauma to the cervix that is significant? A group of lesbians who practiced mechanical masturbation with a phallus were found to have an incidence no higher than among celibate women, suggesting that it is not the physical act of coitus that plays a causative role.

The rarity of this lesion among Jewish women married to circumcised males raised the question of a relationship between circumcision and the induction of cervical neoplasm. Some conflicting reports have appeared, most of which were based on questionnaire-type studies. Our own experience would suggest that women are not aware of whether their husbands have been circumcised, and in fact, a significant number of men have no understanding of whether circumcision has been performed or not. The incidence of cervical carcinoma has been shown to be significantly higher in societies where penile carcinoma is common, as among Indians, Jamaicans and Puerto Ricans, where circumcision is uncommon. A recent report from Puerto Rico by Martinez, I.* showed

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* Martinez, I.: Relationship of squamous cell carcinoma of cervix uteri to squamous cell carcinoma of penis among Puerto Rican women married to men with penile carcinoma. Cancer, 24:777-780, 1969.

a significantly higher incidence of cervical carcinoma among women whose husbands had penile carcinoma. The relationship of circumcision and smegma to cervical carcinoma may thus be a variable, and be related to other factors like frequency of intercourse or multiple sex partners.

Among the other variables studied were frequency of intercourse, place where intercourse was consummated and many other factors. When all significant factors had been considered, the *age at first coitus* appears to be the most significant. We know that during adolescence, the cervix undergoes considerable histologic alterations which is synchronous with the change in the hormonal milieu of the female. If intercourse at an early age is indeed the only significant factor that can be correlated with subsequent development of cervical carcinoma, and we know it is not the mechanical trauma of intercourse that is significant, it must be some agent introduced via the venereal route. Many of the infectious agents that inhabit the vagina have been studied as possible carcinogens in cervical carcinoma. The only agent that meets the epidemiologic criteria is the Herpes virus.

As etiologic agents in the induction of cancer, Herpes viruses have been implicated in renal carcinoma of the frog, lymphoma of chicken, adenocarcinoma of hamsters, leukemia in guinea pigs, lymphoma of the cottontail rabbit and lymphomas of monkeys. In the human being, Burkitt's lymphoma, cervical carcinoma, and nasopharyngeal carcinoma have been strongly suspected to be of viral etiology.

Two serologically and antigenically distinct classes of Herpes virus have been identified, Type I and Type II. The Type I virus is the etiologic agent in most cases of non-genital herpetic infections. It is spread by the oral route and appears clinically as a cold sore. Any antibody to this type of Herpes virus appears early in life and by 5 years of age nearly 40% of children have positive titers. By age 35, nearly 95% of the population have antibodies to Type I Herpes.

TYPE II HERPES

Type II Herpes virus is limited to the genital organs and infects both sexes. Generalized infection occurs in the newborn when the disease is acquired during passage through a vagina or cervix infected by the Type II virus. In the female, the most common site of infection is the cervix and vagina with occasional cases involving the vulva.

Antibody to Type II Herpes virus, in contrast to Type I, appears during adolescence when one might assume sexual activity begins. The incidence of titers to Type II is about 20% at the age of 35 and remains at that level throughout life. The incidence of positive titers to Type II varies with socio-economic groups. The incidence of antibody to Type II among patients with in-situ and invasive cervical carcinoma is nearly 100%, while the antibody to Type I is the same as for the control group.

A clinical study which offers support to these findings has recently been published by Naib, Z. M., *et al.** A significantly higher number of patients who had cytologic evidence of herpetic infection of the cervix subsequently developed cervical neoplasia, as compared to a matched control group.

With the identification of an etiologic agent, a method of dissemination and a time of greatest susceptibility, we have a possible hypothesis: The Herpes Type II virus introduced by the venereal route during the period of adolescence, when the cervix is particularly susceptible, is incorporated into the nuclear material of the cervix. With the dormancy that is typical of viruses it will initiate a chain of intracellular events which, as late as 15 or 20 years later, may culminate in an invasive cervical carcinoma.

* Naib, Z. M., *et al:* Genital herpetic infection. Association with cervical dysplasia and carcinoma. Cancer, 23:940-945, 1969.

QUESTION BOX

(Continued from page 195)

favorably toward its enactment. To date there are 157 sponsors in the Congress for this plan, which is the most-endorsed bill of the many medical care bills in the Congress.

As one who's observed medical care delivery widely, does Iowa compare favorably?

It is with great pride that I answer with a resounding YES! It is my candid opinion, as I travel throughout the country, that the medical profession in Iowa, in its concern to deliver complete medical care to all of its citizens, reflects its dedication to the principles of the American Medical Association in promoting the art and science of Medicine and the betterment of the public health.

Mammography in Diseases of the Breast: A 3-Year Evaluation

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MAMMOGRAPHY, the radiographic examination of the breast, has become an important diagnostic tool in the past decade.

In 1913, Salomon, a German surgeon, first described the radiographic findings of breast diseases using 3,000 mastectomy specimens. First clinical use of mammography was made in 1926 by Stafford Warren. Lockwood, Hicken, Seabold, and Gershon-Cohen also did work in mammography during this period. Technical problems and difficulty in producing quality studies on a large scale caused the clinician to doubt the value of this procedure and interest in mammography declined during the 1940-1950 period. In the early 1960's, Eagan developed a system of mammography which produced diagnostic radiographs. More importantly however this method was reproducible by x-ray technicians in private offices using standard radiographic equipment.[1]

Other diagnostic methods for examination of the breast have been advocated. Xeroradiography utilizes a selenium-coated metal plate in place of the x-ray film. The resulting film is similar to a "positive" print on paper, which gives good detail of the internal structure of the breast.[2] Thermography measures the increased amount of heat produced by breast cancer. A thermographic scan can be performed in 2 minutes, and thus has an excellent screening potential for large groups of women.[3] Difficulty in obtaining equipment together with the expense of examinations make the use of xeroradiography and thermography hard to justify in a community hospital or private office with a small patient volume. Positive contrast studies (the injection of a radiopaque substance in the ducts as they emerge from the nipple), angiography and lymphangiography have also been advocated. We have had experience only with mammography at the University Hospitals and this report reviews our experience from January 1969 to January 1972.

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TECHNIQUE

Meticulous attention must be paid to patient position, radiographic factors and film processing if good quality radiographs are to be obtained. Three views are taken of each breast: medio-lateral and craniocaudad projections of the breast and an anteroposterior projection of the axilla. Comparison is made of the skin, glandular tissue and fat, all of which are nearly the same radiographic density. In order to obtain a diagnostic film, low kilovoltage, 25-40 kV, and high milliamperage, 1800 milliampere seconds, are needed. We use a 300 mA generator and this requires *six* second exposure to obtain the 1800 mAs needed to obtain a satisfactory examination.[4]

The real key to obtaining good film is the x-ray technician. The technician must be trained to position the patient comfortably. Good cooperation from the patient is imperative; she must lie or sit without movement for six seconds.

Special industrial type x-ray film is used and the best quality radiographs are obtained

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY, 1973.

from hand processing. Many modern hospitals no longer have development tanks and x-ray film has been perfected so it can be developed in an automatic processor. Some film detail is lost by automatic processing. However, if all other factors are equal, automatic processing produces satisfactory films.

Six seconds is a long x-ray exposure. Is this an excessive amount of radiation? Radiation dosage varies from 4.8-6.4 rads per examination at 3 cm below the skin surface. Comparing the area of the body irradiated and the quarterly maximum permissible dose, this amount of radiation is not excessive.[5]

The radiograph is first viewed on the standard view box for gross changes in the architecture of the breast. A bright light and magnifying lens are essential for the identification of minute calcifications which are frequently found in areas of malignancy. Figure 1 shows a diagram of the normal breast. It is dense in the pubertal and virginal young adult. This is due to the dense appearance of the well developed glandular tissue. The breast in pregnancy, as expected, is very dense because of the increase in glandular development. In the pre-menopausal breast there is a gradual reduction of glandular tissue which is replaced by adipose tissue. The glandular tissue in the post-menopausal breast is almost completely replaced with fat. The post-menopausal breast with atrophy of the glandular structures and increasing amounts of fatty tissue makes the best subject for mammography. Accuracy figures for the detection of malignancy in the pre-menopausal breast are about 50% while in the post-menopausal breast they are frequently as high as 90%.

INDICATIONS

The indications for mammography are numerous, but they can be grouped into four large categories:

1. *High risk group.*
2. *Aid in the evaluation of suspicious physical findings.*
3. *Cancerophobia.*
4. *Determination of an unknown primary cancer.*

The high risk group includes all women with lumps, or questionable lumps. Mammography is not a substitute for surgical biopsy,

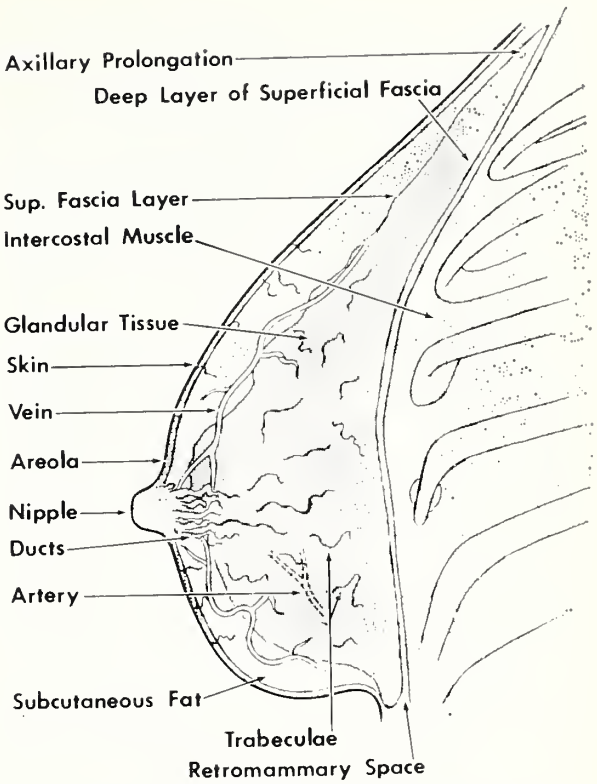


Figure 1. An artist's conception of the appearance of the various anatomic structures of the breast which can be identified on the mammogram. From Egan, Robert L., Mammography, 1964. Courtesy of Charles C Thomas, Publisher, Springfield, Illinois.

but is indicated to properly localize lesions before surgery, to give the surgeon some indication of the extent of the lesion, and probably most importantly, to point out areas of cancer in the opposite breast. Women who have had mastectomy for cancer of the breast can be followed in this manner. A familial history of breast cancer is an indication for close observation of the patient and mammography is a convenient method of followup.

Mammography is indicated in patients with suspicious physical findings or with breasts that are difficult to evaluate. Recent nipple retraction, discharge, or eczema are factors which make examination difficult. Large pendulous breasts present problems of palpation. The abundance of adipose tissue makes these individuals good subjects for mammography. Patients with fibrocystic disease of the breast, predominantly cystic, have multiple small nodules which are difficult to follow by physical examination and these can be observed radiographically.

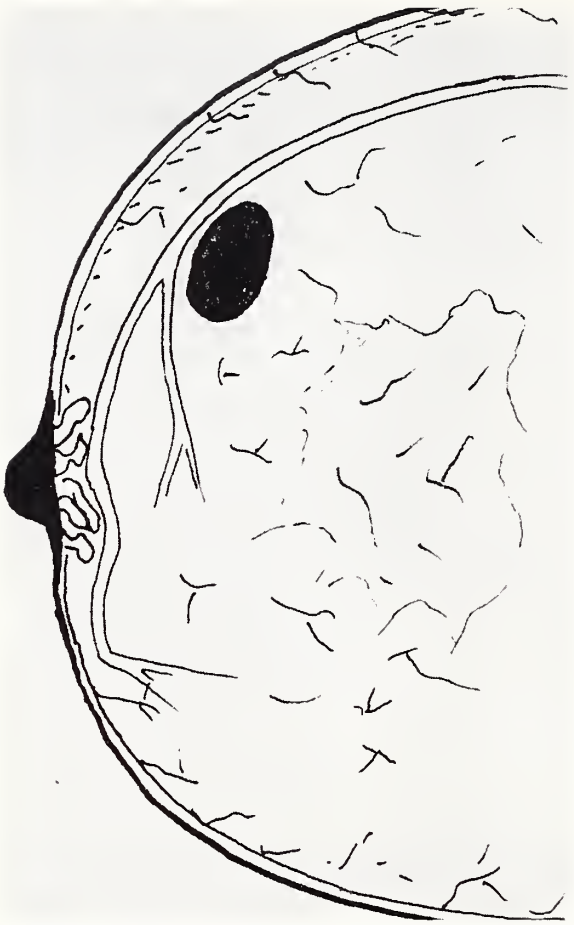


Figure 2. Schematic drawing of a benign mass: rounded or oval, smooth bordered, thin radiolucent surrounding rim of fat, homogeneous, and without secondary changes in the breast. From Egan, Robert L., Technologist Guide to Mammography, 1968. Courtesy of The William & Wilkins Company, Baltimore, Maryland.

Cancerophobia is a good indication. Patients and physicians are usually reassured following mammography and a base line is set up for future examinations.

In a large referral center we see a number of patients who have metastatic cancer. Finding the primary lesion in these patients is often a difficult task. Mammography is an aid in showing the presence or absence of cancer of the breast as the initial lesion.

A very worthwhile use of mammography is the radiographic examination of the surgical specimen. This is particularly helpful in a small biopsy with calcification visualized on the preoperative mammogram. If the area of calcification is not present in the biopsy specimen then the surgeon should attempt to find another area for biopsy. Radiographic examination of the entire surgical specimen is also of value. The specimen is cut into slices 1 cm thick. The slices are laid out on an x-ray film and a radiograph is taken. All areas containing calcification should be examined for carcinoma. This can be of considerable assistance to the pathologist in locating multiple areas of cancer in the surgical specimen.

CLASSIFICATION OF BREAST LESIONS

The main point of mammography is to identify and classify the lesion. From a pathologic point of view there are a number of different forms of both benign and malignant disease. However, benign lesions from a radiographic point of view fall into five large groups: fibrocystic disease, fibroadenoma, intraductal papilloma, miscellaneous benign lesions and inflammatory disease.

Benign lesions are noninvasive lesions. Therefore, if a mass is present, it is a dense, homogenous well demarcated lesion that pushes the parenchyma of the breast away as it enlarges. There is no skin thickening or retraction. Calcifications, if present, are larger than the "grains of sand" seen with malignant disease. They are easily seen without magnification and can be counted. The veins draining the breast and the ductal structures are undisturbed.[6] Figure 2 demonstrates diagrammatically the findings in benign disease.

Fibrocystic disease includes all diseases which are characterized by cyst formation, duct dilatation, lobular or ductal hyperplasia and stromal fibrosis. The following conditions are included in this fairly large heading: fibrocystic mastopathy, chronic cystic mastitis, mammary dysplasia, mastodynia, adenosis, Schimmelbusch's disease, adenocystic disease, microcystic disease, cystic disease, solitary cysts, polycystic disease, mazoplasia and sclerosing or fibrosing adenosis. These lesions are thought to result from exaggeration of cyclic changes during the menstrual cycle. The lesions are reported radiographically as, fibrocystic disease with the dominant tissue component, i.e., predominantly cystic, predominantly fibrous, predominantly lobular hyperplasia, predominantly ductal or mixed types.

Fibroadenoma appears as a single homogenous, dense, well demarcated lesion. Cystosarcoma Phylloides is a giant fibroadenoma which is usually a benign lesion, however, 10% may be malignant.

Intraductal papilloma is a fairly common lesion, and while the lesion itself cannot often be visualized the dilated ducts are visualized behind the nipple. This is especially true in post-menopausal breasts. A nipple discharge plus dilated ducts makes the diagnosis.

A number of miscellaneous lesions such as gynecomastia, plasma cell mastitis, mammary duct ectasia, galactoceles, lipoma and hematoma are uncommon lesions which have characteristic findings. Breasts prosthesis and augmentation mammoplasty are rare at the University Hospital Clinics. The findings of the prosthetic sponges are diagnostic.

Inflammatory diseases at our hospital are also very rare with the diagnosis having been made only once in our series.

The primary signs of malignancy are a mass which is dense, nonhomogeneous and irregular in outline. The margins of the lesion are spiculated and the mass feels larger to palpation than it appears radiographically. Calcifications, if present, are like "grains of sand," are not countable and are limited to a definite area of the breast.

The secondary signs of cancer of the breast are skin retraction, skin thickening, increased vascularity, nipple and areolar changes, changes in the breast stroma, i.e., asymmetry of the architecture of the breast, changes in the course of the ducts and invasion of the retromammary space. Lymph nodes are sometimes demonstrated in the axilla. Figure 3 demonstrates diagrammatically the findings in malignant disease.



Figure 3. Schematic drawing of a cancer, showing several primary, as well as secondary signs of cancer. The primary signs are increased in density of the mass compared with surrounding tissue, dense center and less dense periphery, and spiculated appearance of the mass. The secondary signs include thickening, flattening and retraction of the skin, increased vascularity, and nipple retraction. From Egan, Robert L., Technologist Guide to Mammography, 1968, Courtesy of The Williams & Wilkins Company, Baltimore, Maryland.

RESULTS

We began using the technique developed by Egan on January 1, 1969. During the three year period ending January 1, 1972, we performed 311 mammograms (see Table I). The indications as listed by the referring physician are as follows:

Breast mass	145
History of breast cancer	28
Family history of breast cancer	8

TABLE I

SUMMARY OF 3-YEAR MAMMOGRAPHY STUDY

Year	Mammograms	Biopsy	Correct		Incorrect	
			Benign	Malignant	Benign	Malignant
1969	104	54	26	21	4	3
1970	105	47	25	16	3	3
1971	102	42	19	12	10	1
Total	311	143	69	50	17	7
Percentage					11.9%	4.9%

Nipple discharge	27
Painful breast	18
Unknown primary	40
Cancerophobia	7
Other	24
No indication given	10
Lost to followup	4

Of the 40 patients with an "unknown primary" listed as the indication, 13 patients had a final diagnosis of metastatic carcinoma, primary unknown. The remaining primary lesions were lung 6, breast 3, pancreas 2, reticulum sarcoma of bone 1, ovary 1, uterus 1, myelogenous leukemia 1, hypernephroma 1, organic brain disease 2, metastatic lesion to brain 2, and cavernous angioma of skull 1. Cancer of the breast was demonstrated in one of the three cases having metastatic breast carcinoma. In the remaining patients with unknown primaries, no breast lesions were found.

The "other group" included 7 patients with large breasts. Ten patients had repeat or follow up examinations for benign disease. One patient had lymphedema of the skin secondary to Hodgkins disease and was re-evaluated. Another patient had lymphedema for which no cause was found. One patient was examined after treatment of a breast abscess, one patient had an inverted nipple, and another was examined as part of a work up for carcinoma of the cervix.

In this group of 311 mammograms, 143 patients had surgical biopsies. A breast mass was located radiographically in 76 of these biopsied cases. In 19 of the entire group of 311 cases, masses were noted radiographically but were not palpated by the referring physician. Seven of these lesions were benign, two were malignant, and 10 were not biopsied.

Lesions marked as either "suspicious or malignant" which proved to be benign at biopsy were 11.9%. Those lesions diagnosed as "benign" but were malignant at biopsy were 4.9%. The accuracy rate has been quoted as between 70-85% in most large series and as high as 90% in one series of cases.[7]

CONCLUSION

1. Mammography is a valuable diagnostic tool.

2. Meticulous attention to the details of radiographic technique is necessary for the production of diagnostic radiographs.

3. Our accuracy rate was 83% correct diagnosis in all of the biopsied specimens. Our 11.9% incorrect rate for benign disease is acceptable. Our 4.9% incorrect rate in malignant disease is comparable to other investigations in the field and close review of the films with the surgeon is imperative to reduce this figure.

4. We do not feel this is a screening procedure for large groups of women. The use of thermography with the radiographic examination of the positive thermograms seems to be the procedure for screening large numbers of patients. More work using this combination of modalities is needed before a definite conclusion can be reached.

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SUMMARY OF IMS GROUP COVERAGES

(Continued from page 196)

may apply for a basic daily benefit without evidence of insurability. The plan provides extra income when hospital confined. Coverage begins with the first day of hospitalization and pays up to 365 days for each sickness or accident. Benefits are available from $20 to $60 per day regardless of personal or group medical insurance. It is guaranteed renewable to age 70.

The Society's Committee on Group Insurance counsels with officials of The Prouty Company as new programs or changes in existing programs become available and desirable. Further information on any of the programs will be provided through an inquiry to IMS headquarters.

Clinical Use of the Gravlee Jet Washer

A. JAMES WHITE, M.D.,
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HERBERT J. BUCHSBAUM, M.D.
Iowa City

The incidence of endometrial carcinoma has increased in recent years, while that of cervical carcinoma has decreased.[1] The detection of pre-invasive cervical cancer by cytologic techniques has resulted in a lowered incidence and death rate. The increase in deaths from cancer of the corpus is due to the absence of a simple screening test for this disease. Procedures utilizing cervical or vaginal smears will detect only 50-60% of cases of endometrial cancer.[2] Metal and plastic cannulas,[3, 4] and positive pressure lavage have been used in attempts at early detection of endometrial neoplasm. Biopsies and aspirates obtained with cannulas sample only a small area of the endometrium, however, and positive pressure lavage may expel malignant tissue through the fallopian tubes or into the vasculature.

A satisfactory cytologic method for sampling the endometrium has recently become available. In 1964, Dowling and Gravlee described a new instrument for sampling the endometrium by negative pressure lavage.[5] This procedure is easily performed in the office, requires no analgesia, and causes little or no discomfort. This paper reports a study devised to evaluate the efficacy of the jet washer in ordinary clinical situations. We have also compared our results with those in other reports.

Drs. White and Buchsbaum are associated with the Department of Obstetrics and Gynecology, and Dr. Rodman is a member of the Pathology Department, at The University of Iowa College of Medicine. Dr. White is an American Cancer Society Clinical Fellow in Gynecologic Oncology and a Fellow of NIH Clinical Cancer Training Grant T12 CA 08084. This study has been supported in part by an award from The Upjohn Company, Kalamazoo, Michigan.

MATERIALS AND METHODS

Endometrial jet wash specimens were obtained by members of the Department of Gynecology, from either awake or anesthetized patients. By withdrawing the syringe plunger of the Gravlee jet washer* (Figure 1), a vacuum

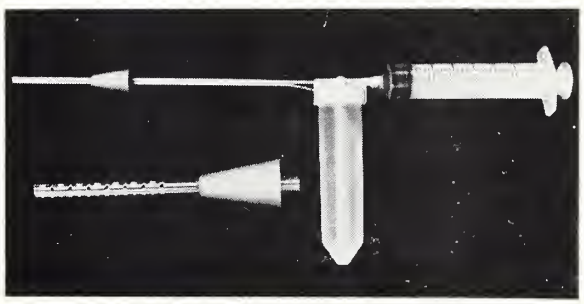


Figure 1. The Gravlee jet washer as it appears when assembled. The insert shows an enlarged view of the tip. The vacuum created by activating the syringe draws saline from the reservoir into the endometrial cavity. Cells from the surface are then collected in the syringe.

was applied to the endometrial cavity. The vacuum, transmitted to the reservoir, pulled saline out through multiple holes in the tip. Jets of saline were thus forced against the cavity lining. The specimen was finally collected in the syringe and promptly delivered by messenger to the cytopathology laboratory. Samples early in the series were passed through Millipore® filter with pores of 8 μ diameter. Visible pieces of tissue were removed from the filter surface, fixed in 4% buffered formaldehyde, dehydrated in ethanol, and embedded in paraffin. The filter with entrapped cells was stained with the Papanicolaou stain technique, and 4 μ thick sections of the paraf-

* Upjohn Company, Kalamazoo, Michigan.

fin embedded tissue were stained with Hematoxylin and Eosin. Samples obtained later in the series were centrifuged at 150 × G for 5 minutes and the sediment fixed by resuspension in 10-20 volumes of Zenker's solution. After 10-20 minutes the sample was recentrifuged, and, if the "button" of tissue thus formed was friable, acetone was added to harden the specimen. It was again centrifuged, dehydrated, and embedded in paraffin. Later in the series the Millipore® filter step was omitted in all but scanty samples. Cytologic interpretation was correlated with interpretation of histologic material obtained by endometrial biopsy, curettage, or hysterectomy.

RESULTS

One hundred twenty-nine jet washes were done on the Gynecology Service at the University Hospitals from September 1970 to January 1972. The indications for jet wash are listed in Table I. The majority were done for abnormal vaginal bleeding of unknown cause, or for known gynecologic malignancy. One hundred eight jet wash specimens, or 84% of the total, were satisfactory. The 21 unsatisfactory specimens were so judged because of inadequate material in the sample. There was histologic material available for correlation in 84 instances. In 73 (87%) of these specimens there was positive correlation between jet wash and histologic samples.

TABLE I
INDICATIONS FOR SAMPLING

	No. of Specimens
Post-menopausal bleeding	45
Abnormal peri-menopausal bleeding	13
Abnormal pre-menopausal bleeding	9
Known malignancy	30
Followup of abnormality	12
Abnormal cytologic smear	6
Routine gynecologic screening	6
Miscellaneous	8
Total	129

There were two false positive aspirations. In each case, adenocarcinoma was strongly suspected, but curettage showed no evidence of malignancy.

There were six cases in which the jet washings were suspicious for malignancy. In five instances, subsequent curettage revealed normal tissue. The sixth patient had a suspicious jet wash six months after a full course of radiation therapy. Cytologic changes indicative of radiation effect were also present. A subsequent curettage showed radiation effect but no evidence of malignancy.

There were three false negative specimens in this series. One patient had uterine carcinosarcoma, another had endometrial polyps with focal atypical hyperplasia, and the third had endometrial adenocarcinoma. Atypical cells were not identified in material obtained by jet wash from any of these patients.

Twenty-nine of the 31 jet wash specimens from patients with endometrial adenocarcinoma were satisfactory for diagnosis. A positive correlation was obtained in 28 of the 29 cases where the jet wash was adequate. The 28 specimens were reported as "conclusive for carcinoma" (14), "suspicious" or "strongly suspicious" (11), and "atypical hyperplasia" (3).

CASE REPORT

The following case report illustrates an example of good correlation between jet wash and tissue samples and use of the jet wash specimens in patient management.

R. M. was 65 years old, para 3-0-0-2, and had a curettage at another hospital on 10/26/71 for postmenopausal bleeding. Histopathologic study revealed adenocarcinoma with extension to the endocervix. She was admitted to the University Hospitals on 11/2/71, and classified as having Stage II adenocarcinoma of the endometrium. A tumor survey, consisting of intravenous pyelogram, cystoscopic and sigmoidoscopic examinations, barium enema, chest x-ray, and blood chemical analyses revealed no evidence of metastases.

She received 4000 rad. Cobalt 60 tumor dose through 16 x 16 cm anterior and posterior pelvic fields. On 12/10/71, a Gravlee jet wash, endometrial curettage, and Heyman packing of the uterus were done under general anesthesia. The jet wash specimen contained groups of cells conclusive for adenocarcinoma of the endometrium (Figure 2), and the curettage specimen also contained adenocarcinoma (Figure 3). A second Gravlee jet wash, curettage and Heyman packing was performed on 1/3/72. Both the jet wash (Figure 4) and

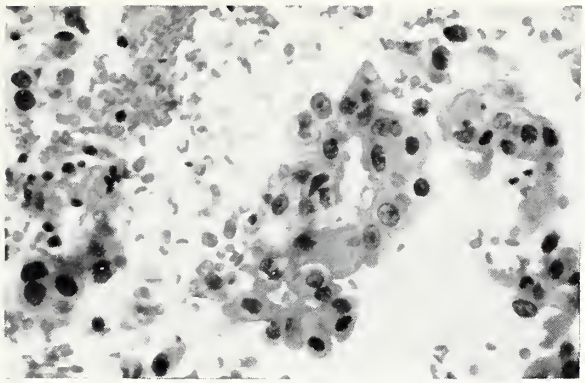


Figure 2. A photomicrograph of a microbiopsy in the first jet wash specimen. There are elongated and rounded clusters of malignant epithelial cells. Nuclei vary greatly in their size, shape, staining property, and chromatin distribution. This specimen was interpreted as conclusive for adenocarcinoma. X 440.

curettage specimens (Figure 5) contained adenocarcinoma, as well as radiation effect. A jet wash specimen obtained on 5/16/72 (not included in the series) contained cells with radiation changes. Since there was no residual neoplasm, the patient will be observed with subsequent jet washes.

Therapeutic Control with Jet Washer

Several patients have been followed with more than one jet wash. Table II shows the number of jet washes per patient. In many instances persistent or recurrent cancer after radiation therapy was detected in the jet wash specimen. For example, in the case reported above, endometrial carcinoma was again demonstrated in the jet wash specimen one month after radiation therapy (See Figure 4). Another patient had Stage I adenocarcinoma of the endometrium, but hysterectomy was not performed because of severe medical problems. She received two Heyman packings, and has been followed with four jet washes performed at three month intervals. Endometrial lavages have shown no evidence of recurrent carcinoma.

TABLE II

JET WASHES PER PATIENT

Number of Washes	Number of Patients
1	113
2	12
3	2
4	2
Total	129

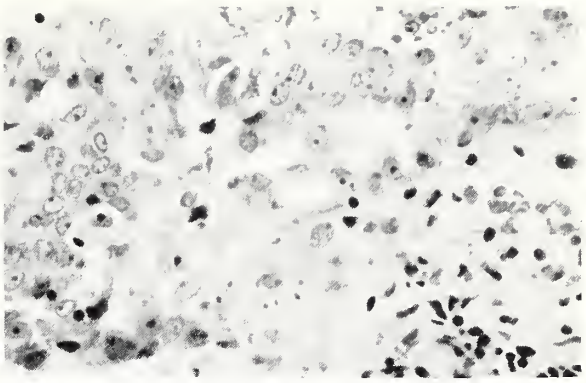


Figure 3. A photomicrograph of our first curettage specimen from which a diagnosis of endometrial adenocarcinoma was established. Disoriented, irregularly arranged, neoplastic columnar epithelial cells form a severely distorted gland-like structure. A small amount of stroma is adjacent, in the lower right. Neoplastic epithelial cell nuclei frequently have prominent nucleoli, while a few nuclei are uniformly deeply stained X 440.

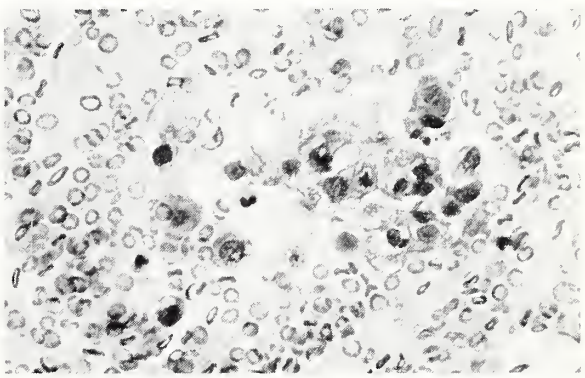


Figure 4. A photomicrograph of a cluster of epithelial cells among erythrocytes in the jet wash specimen obtained after radiation therapy. Nuclei are enlarged with bizarre shapes and irregularly distributed chromatin. The cytoplasm of several cells is voluminous and irregularly stained. These cells were interpreted as conclusive for residual adenocarcinoma and were thought to exhibit radiation change. X 650.

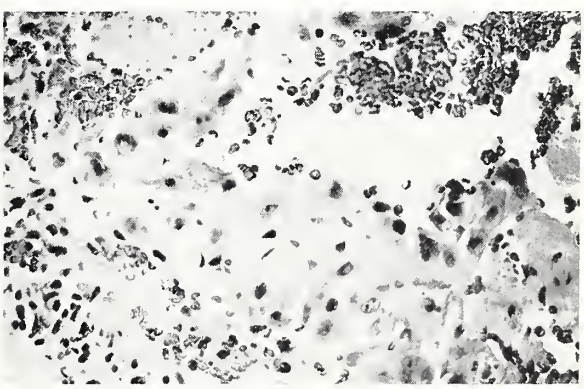


Figure 5. A photomicrograph of a portion of the curettage specimen obtained just after the jet wash procedure illustrated in Fig. 4. Irradiated tumor cells are in the center with variable bizarre nuclei and voluminous cytoplasm which stained irregularly. Necrotic tissue and leukocytes are to the left. X 650.

Cytologic Interpretation Other Than Malignancy

Several different positive interpretations other than malignant disease have been possible. In three jet washes from patients with previous radiation therapy, radiation changes were identified. These included large nuclei with prominent nucleoli and voluminous, irregularly staining, vacuolated cytoplasm (See Figure 4).

In two other patients in whom curettage had been performed one to two weeks prior to jet wash, evidence of regeneration was noted. There was fibrovascular proliferation in tissue fragments covered by actively regenerating columnar epithelium.

Complications

In one unanesthetized patient, the Gravlee instrument perforated the uterus. Two hundred milliliters of ascitic fluid was aspirated from the peritoneal cavity with the jet washer. There was no cytologic evidence of malignancy. The patient has suffered no apparent ill effects from this incident.

DISCUSSION

We have found the Gravlee Jet Washer to be a useful and reliable tool for the detection of endometrial cancer. Of 129 consecutive specimens obtained with the jet washer, 108 were satisfactory, and tissue was available for correlation in 84. Correlation was accurate in 73 instances, or 87% of these 84 specimens.

Our series of jet washes is unusual in that there are many cases of malignancy. Thirty-one patients had adenocarcinoma of the endometrium, one had carcinosarcoma, and one had a polyp with focal premalignant changes. These 33 cases represent 25% of the total specimens. In comparison, the series reported by Gravlee had 1500 jet washes and only 3% with malignancy.[6, 7] This high number of malignant samples in our series is related to the referral pattern to the Gynecologic Oncology Service at the University of Iowa. This service had an accession of 45 new cases of endometrial carcinoma in 1971. Many of these patients had a prior diagnosis of endometrial cancer established from tissue obtained by curettage in outlying hospitals.

Three false negative specimens out of 108 satisfactory samples is an artificially high number. In one case, a jet wash was done 12 days after curettage revealed endometrial adenocarcinoma. Although residual malignancy was found in the endometrium at the time of hysterectomy, it is not surprising that the jet wash was negative.

The second false negative sample was obtained from a patient with endometrial carcinosarcoma. Gravlee detected only 3 out of 6 sarcomas in his series.[6] This malignancy may have characteristics which make the jet wash technique ineffectual for diagnosis. Stromal fragments of these tumors may be more exuberant but harder to dislodge than epithelial components.

The third false negative jet wash occurred in a patient who had an endometrial polyp with focal adenomatous hyperplasia. Although Bibbo reported detection of eight cases of adenomatous hyperplasia with the jet wash technique, one patient with a benign endometrial polyp had an inadequate jet wash specimen.[8] It is possible that polyps inhibit turbulence necessary for removal of epithelial cells or groups of cells.

Handling of jet wash specimens for optimal benefit to the patient requires the utmost in cooperation and expertise by the clinician and the cytopathologist and their respective teams. When specimens are handled properly, the cells are better preserved than endometrial cells from the vaginal pool. Small pieces of tissue may be found in the jet wash specimen, and these "microbiopsies" have enabled the cytopathologist to report a specimen as *conclusive* for malignancy. A positive jet wash specimen with microbiopsies is similar to malignant tissue obtained by other techniques. In these cases, the clinician may confidently begin treatment without resorting to endometrial curettage.

We have found that careful supervision of technological procedures is important in order to achieve maximum accuracy. Each specimen requires individual specific judgments regarding processing techniques. For example, the specimen which appears scanty should be filtered and the filter surface should be observed carefully for tissue fragments which may be removed with forceps and processed for sectioning. On the other hand, a bloody specimen should not be filtered because erythrocytes entrapped in the Millipore® or other suction filter will obscure epithelial cell detail. Such

specimens should be handled by one of the centrifugation techniques.

Table III shows the diagnostic accuracy of our series as well as that of other investigators. The diagnostic accuracy is the number of positive washes for each diagnosis of malignancy made by tissue examination. We have included the three false negatives in calculating this figure.

In evaluating the accuracy of the Gravlee jet washer, we have noted that an unsatisfactory specimen may result when malignancy is present. Gravlee noted three undetected malignancies in 397 jet washes. So-Bosita and Hibbard found none, and the present series includes two undetected malignancies in 21 unsatisfactory specimens. It is apparent that a report of an unsatisfactory jet wash must not lead to a conclusion of absence of neoplasia.

The jet washer has many advantages over conventional methods of endometrial sampling. It is as accurate as other biopsy techniques. In comparison with our 90% accuracy with the Gravlee jet washer, Slaughter[11] obtained 76% accuracy with the Novak curette, and McGuire[12] reported an accuracy of 87%. In theory, the Gravlee jet washer samples all surfaces of the endometrium, whereas a curette may not. The jet washer is less hazardous than other lavage methods, since tissue is not forced out of the fallopian tubes.[13] There has been good physician acceptance of this technique at our institution because the jet washer is prepackaged and disposable, and the cannula does not require dilation of the cervix.

TABLE III

ACCURACY OF JET WASHER

Author	Jet Washer/Malignancies	Diagnostic Accuracy %
Gravlee[6,7]	51/55	93
So-Bosita[9]	5/7	72
Hibbard[10]	6/6	100
Present series	28/31	90

SUMMARY

Indications for and results of 129 consecutive endometrial jet washes are presented. Eighty-four per cent of the specimens were satisfactory for interpretation, with positive correlation in 86%. A case presentation illustrates identification of endometrial carcinoma in the jet wash specimen, and use of this technique in later therapeutic management. Possible causes for erroneous interpretations are discussed.

REFERENCES

The references noted in this article are available from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Continuing Education Courses & Conferences

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May 10-12	Iowa Eye Association
May 16-17	Seminar on Principles of Pesticide Epidemiology
May 26-27	Workshop on Quality Assurance Programs in Community Haspitals (Holiday Inn—Amana)
June 4-7	Training for Physicians in Coranary-Care-Unit Techniques
June 13-14	Seminar an Treatment of Human Sexual Inadequacy (Conference Center—Carousel Motel—Iawa City)
July 11	Community Clinical Conference Dealing With Emergencies (Broadlawns Polk County Hospital—Des Moines)
July 25-26	1973 Refresher Caurse far Family Physican "Mini-Version"
July 27	Workshop on Preceptorships and Teaching Skills for Practicing Physicians

Unless otherwise specified all courses and conferences are held at The U. of I. College of Medicine, Iowa City.

Endoscopic Pancreatocholangiography and Coloscopy

JAMES W. MANIER, M.D.
Iowa City

Gastrointestinal endoscopy has come of age in the past 10 years.[1] This has resulted from the development of fiberoptic endoscopes. Major advancements in instrumentation are occurring at such a rapid rate that it is difficult to keep up with the new developments. It will be the purpose of this paper to describe endoscopic cannulation of the pancreatic and biliary ducts, and coloscopy, two new endoscopic procedures recently introduced at the University of Iowa.

Endoscopic Cannulization of the Pancreatic and Biliary Ducts: Better diagnostic methods have been needed in the diagnosis of biliary and pancreatic disease. Within the past three years Japanese investigators have developed endoscopic techniques for cannulization of the pancreatic and biliary ductal systems utilizing a side-viewing fiberoptic duodenoscope equipped with a plastic cannula which can be inserted under direct vision into the orifice of the ampulla of Vater.[2] This procedure has now been introduced into the United States, where several workers have become proficient enough at the technique to accomplish cannulization in the range of 80-90 per cent of their attempts.[3] The procedure is now under development in the Section of Gastroenterology at The University of Iowa Hospitals.

The most important indication for the procedure is in the differential diagnosis of obstructive jaundice. Strictures, stones, tumors and sclerosing cholangitis involving the common bile duct can be demonstrated. Tumors and strictures or stones of the major pancreatic duct can be shown, thus assisting the surgeon in determining a surgical attack on the pancreas. Experience to date would suggest that the procedure will be of more use in disease of the common bile duct than the pancreas. Carcinoma of the head of the pancreas and of the ampulla of Vater can occasionally be diagnosed by direct visualization of the tumor with the scope, and since a biopsy forceps can be passed through the cannual channel, a biopsy can also be obtained.

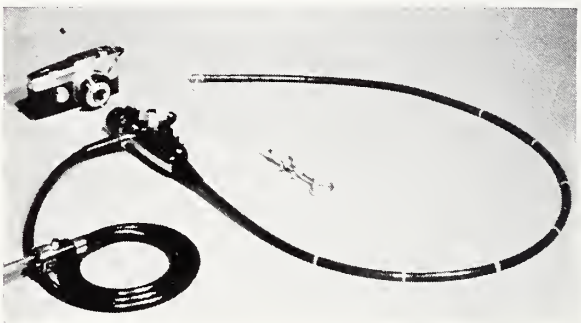


Figure 1. Olympus side viewing duodenoscope.

Patients to be considered for the procedure must be able to tolerate anesthesia with diazepam (Valium®) administered to the point that there is a slight delay in response to verbal commands. Thus, patients in impending hepatic coma or renal shut down, or with severe pulmonary or cardiovascular disease would not qualify as candidates for the examination. Bleeding parameters also should be within a range to allow endoscopic biopsy if necessary, i.e., a prothrombin within four seconds of control, a platelet count over 80,000/cu mm, and a partial thromboplastin time within one and a half times of normal.

Patients are examined in an X-ray fluoroscopic room utilizing a side-viewing fiberoptic duodenoscope (Figure 1). Duodenal relaxation

Dr. Manier is an associate professor in the Department of Medicine at The University of Iowa College of Medicine.

is obtained using dicylomine HCl (Bentyl®) 60 mg and Atropine 0.6 mg given intravenously at the start of the study. The scope is introduced rapidly through the esophagus and stomach, and into the duodenum. The ampulla of Vater is identified and a small plastic cannula introduced through the instrument channel of the scope and into the ductal orifice of the ampulla. The pancreatic and common bile ducts are visualized using 30 per cent solution of meglumine diatrizoate and sodium diastrizoate (Renografin®) injected through the cannula. Figure 2 shows the normal appearance of the common bile and pancreatic ducts when visualized by this technique.

Difficulties with the procedure include such technical problems as: 1) introducing the scope, 2) identifying the ampulla of Vater which may appear as a raised excrescence on the posterior medial wall of the duodenum or merely a discrete reddish area lying between two folds depending on the degree of muscular relaxation of the duodenum, 3) problems identifying and cannulating the duct orifice, and 4) difficulty filling the duct system one wishes to study.

Complications of the procedure are several. While only infrequently noted, acute pancreatitis is related to the force used and the rapidity of injection of the contrast media as well as the concentration of the media, being seen much more commonly with 60 per cent than 30 per cent Renografin®. Hyperamylasemia has been seen somewhat more frequently but is of short duration and apparently benign in its effects.[3] Septicemia has been noted.[4] There is always the possibility of instrument contamination with subsequent transmission of hepatitis.

The instruments used are expensive, costing in the vicinity of $5000. They have limited use since the forward-viewing scopes are of more value in diagnostic upper gastrointestinal endoscopy where they allow better visualization of the esophagus, stomach, and duodenum, and are technically easier to use. Further, the smaller fiberoptic light and viewing bundles of the side-viewing scopes require a larger light source if endoscopic cinephotography is to be performed, adding an additional $5000 to the cost. An X-ray suite equipped with image intensification and an automatic film changer are also needed. The procedure frequently requires as long as two hours to perform, during which time the services of a radiologist and a radiology technician are required in addition to the endoscopist. This has led Morrissey[5] recently to suggest that it currently seems more reasonable to develop the technique in certain hospitals rather than every hospital in an area.



Figure 2. Radiograph of a normal choledochus and pancreatic duct demonstrated by means of retrograde cannulization of the ampulla of Vater.

The value of the procedure in the carefully selected patient is emphasized by the following case. This 45-year-old woman had been under therapy with chloropromazine HCl (Thorazine®) for a chronic schizophrenic reaction when she developed progressive jaundice and liver function studies compatible with either an intrahepatic cholestosis or biliary tract obstruction. Because of her schizophrenia, surgical exploration was not felt advisable unless she had extrahepatic biliary obstruction. Endoscopic biliary tract cannulization revealed a common duct stone (Figure 3) subsequently confirmed at surgery. Chloropromazine HCl could be continued, thus making the patient's postoperative management easier.

COLOSCOPY

The earliest attempts at fiberoptic coloscopy date to 1963.[6] The limitations of conventional sigmoidoscopy and radiology have stimulated the subsequent rapid developments in this area of gastrointestinal endoscopy. Early in the introduction of this technique problems such



Figure 3. Common duct stones. One arrow points to stone impacted at the ampulla. The second arrow points to stone in the mid duct.

as difficulty with scope mobility, lack of an adequate tip control, and insufficient length of the available instruments to allow routine visualization of the entire colon severely hampered development. Recent innovations including polydirectional tip control, lengthening of available instruments from 105 cm to 187 cm, and the use of a movable rigid sheath to be slipped over the scope to straighten out the sigmoid colonic curve have resolved many of the early problems. With increasing experience with the instrument we have found that we can routinely reach the cecum in 90 per cent of our patients and within 15 to 45 minutes.

Indications for coloscopy include doubtful lesions on routine and double-contrast barium enemas. In this group are: 1) patients in whom the cecum has been inadequately demonstrated, 2) where polyps are felt to exist but feces as the basis for the radiographic findings can't be excluded on multiple examinations, 3) patients with diverticulitis and a questionable cancer, 4) where biopsy is desired, and 5) unexplained bleeding. In patients with occult hemorrhage occasionally conventional proctoscopy and radiology have been negative and we have been able to demonstrate a lesion such as a polyp (Figure 4). A negative procedure may be reassuring in regard to the absence of a malignancy. Further, in the patient with a history of lower bowel bleeding who has had a negative coloscopy, an angiogram is indicated when they next bleed in order to discover lesions such as angiomata and diverticula. 6) Inflammatory bowel disease is another indication. In extensive or rightsided disease the coloscope is valuable in obtaining biopsy material. Followup on the results of therapy may also help in management of patients with Crohn's colitis who often lack sigmoidoscopically defined lesions. In chronic ulcerative colitis of many years' duration in whom carcinoma is a serious problem, periodic coloscopy with biopsy may allow earlier diagnosis, a possibility we hope to evaluate. 7) Coloscopy is indicated in patients with unexplained lower abdominal pain despite normal barium contrast films, sigmoidoscopy, and I.V. pyelography. In 208 patients of this type Shinya[7] found definite colonic pathology in 29 patients with negative, and in 15 others with equivocal barium enemas. We have had a similar experience.



Figure 4. Colonic polyp partially covered with mucus and other debris.

OPERATING HELP

Coloscopy can also be of help at the operating table. The surgeon can telescope the bowel over the instrument so that the whole colon can be visualized by the endoscopist in as little as 10 minutes. Identification and accurate localization of small non-palpable mucosal lesions is thus possible.

The advent of the coloscopic diathermy snare has made it possible to remove colonic polyps without operation and colotomy.[8] Generally, removal of one polyp at a time is preferred since polyps cannot be removed through the scope and thus require removal of the scope and snare with each polyp. If the bowel

is properly prepared Shinya doesn't feel that carbon dioxide need be insufflated to prevent explosion secondary to spark from the diathermy snare. We, however, feel more comfortable insufflating carbon dioxide.

Preparation for coloscopy requires the use of a clear surgical diet for 48 hours before the procedure, 45 ml of castor oil the night before the examination, and cleansing enemas the morning of the endoscopy. Most patients require no anesthesia but some need diazepam (Valium®) administered intravenously until speech becomes slurred, and an occasional patient will benefit from 50 to 100 mg of meperidine (Demerol®) intramuscularly.

Patients should be in clinical condition to tolerate the cleansing preparation and the preoperative medication. Despite the newer modifications of instrument controls, the totally unprepared patient can't be examined. The patient, as in retrograde ductal visualization, must have the same coagulation parameters in order to allow endoscopic biopsy and use of the diathermy snare.

Patients are examined in a room equipped with a fluoroscope so that we can establish the location of the scope if the cecum can't be reached. Figure 5 depicts the scope. It is introduced with the patient in the left lateral decubitus position. We prefer to introduce the scope with an assistant who views the bowel through an attached teaching scope. He helps by moving the scope while we handle fine direction movements using the tip control.

Our experience to date would indicate that the use of this instrument will considerably improve diagnostic accuracy in colonic disease. While the procedure does require technical expertise, this can be rapidly gained. Scopes are expensive; approximately $5000. However, the savings in unnecessary surgery from polypectomy alone would seem adequate to justify the cost in resources, manpower, and time involved.

SUMMARY

Two new endoscopic instruments, the side-viewing duodenoscope for cannulating and visualizing the pancreatic and biliary ductal system, and the colonoscope for diagnostic and surgical procedures on the entire colon are described. Details of the indications for their use, patient preparation for the examination, and technical details of the procedures are described. While probably not necessary for every hospital because of the need for trained endoscopists and the cost of the instruments, it is felt that such techniques should be available to all physicians for their patients through their area tertiary care center.



Figure 5. ACMI 105cm colonoscope.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

CANCER

"While there are several chronic diseases more destructive to life than cancer none is more feared."—*Charles H. Mayo* (1865-1939) *

"Experience has proved the toad to be endowed with valuable qualities. If you run a stick through three toads, and, after having dried them in the sun, apply them to any pestilent tumour, they draw out all the poison, and the malady will disappear."—*Martin Luther* (1483-1546) *

The quotation from Charles H. Mayo, M.D., emphasizes the observation of Martin Luther. Cancer has been responsible for numerous quack ventures, many serious research projects, and much valid concern by the medical profession. The scientific presentations in this issue of the JOURNAL center around the subject of cancer. The four perspectives of the epidemiology of cancer serve as a springboard to the consideration of this plague upon man. The approaches to diagnosis are varied—endoscopic visualization, x-ray projection, surgical biopsy are each important in relationship to the organ system involved.

Our presentations this month, though not a complete monograph on cancer, should impress us again of the magnitude of the problem. Our February JOURNAL was devoted to the kidney and its malfunctions. We hope this grouping of JOURNAL content into a single subject area is pleasing to the readers.—*M.E.A.*

* Strauss, Maurice B.: 1968 Familiar Medical Quotations. Boston, Little, Brown and Co. p.47, p. 492.

A CHOICE IS YOURS

Some time ago I saw an exhibit about surgical sutures. Much emphasis was placed upon the correct type being used with certain surgical procedures. Numerous types of suture material are available—braided silk, gut, monofilament nylon (clear or green), cotton, polyester fiber and steel. These are available in various sizes and strengths. Some are nonabsorbable, others absorbable to varying degrees. They are available with numerous sizes and variations of needles—taper point, reverse cutting, ½ curved, ⅜ circle and straight. I suppose all this is important to a surgeon, but as a pediatrician it is to me only of interest rather than important.

Now, at this time of the year I would not dismiss the entire subject of elongated, slender, cylindrical strands of material used to bind or hold together. Did you know that in some instances men choose such material more seriously than surgeons choose sutures? In fact, they may be more meticulous than they were in the selection of their spouse. Some prefer ultra-light monofilament; others prefer the oval-braided lubricated type. The manner of usage combined with the experience and knowledge of the individual will often dictate variations in the materials used. Sometimes the color will have a strong bearing on the selection—some prefer green, others clear; even fluorescent could be the choice.

Furthermore, as indicated in brochures presented by suture manufacturers, the manner of use is important. The type of knot used in

securing the material becomes a subject of its own.

So it is with bass fishermen, or specialists with trout. Be selective of your line as well as the other needs of the sport. I have never heard a surgeon tell his scrub-nurse to "gimme some string." Be specific when buying fishing line too. You might catch more and bigger fish. At least it puts the whole subject on a more scientific level.—*M.E.A.*

PREDNISONE TREATMENT FOR BELL'S PALSY

The treatment of idiopathic facial paralysis (Bell's palsy) has been studied in the past under rather fragmented controls. Various medical disciplines have treated this enigma of edema and paralysis of the facial nerve in the temporal bone. The two current hypotheses concerning pathogenesis assume an ischemic process . . . dysfunction of the autonomic nervous system causing arteriolar spasm and thromboses in the vessels supplying the nerve, or a primary inflammation of the nerve causing edema and subsequent disturbance of the microcirculation of the nerve.

Surgical decompression of the nerve had been disappointing to Adour, *et al,** but a favorable response was noted to therapy with prednisone. The report by these workers from the Facial Paralysis Research Clinic, Kaiser-Permanente Medical Center, Oakland, California, considers the effects of prednisone administered orally to 194 patients compared to 110 untreated patients. The results in patients treated with prednisone were rated superior; complete denervation developed in none of the treated cases, while such did develop in 10 per cent of the untreated group. Fewer than 4 per cent of the patients who received prednisone had complications related to its use.

The report concludes with these suggestions for treatment of idiopathic facial paralysis: (1) rule out other disease, and (2) treat all patients with prednisone (unless for some reason it is contraindicated) as soon as possible after onset of the palsy. The dose for adults has been arbitrarily set at 60 mg of prednisone daily for 4 days and tapered to 5 mg per day in 10 days. The patients should be evaluated every 2-3 days and the prednisone therapy altered as necessary. The suggestion is made by this study that oral administration of prednisone obviates the need for surgical decompression.—M.E.A.

* Adour, K. K., *et al:* Prednisone treatment for idiopathic facial paralysis (Bell's Palsy). New Eng. J. Med., **287**:1268-1272, Dec. 21, 1972.

WELL DONE, HPCI

Approximately seven years ago the Health Planning Council of Iowa was created as a voluntary organization to assist Iowans in health planning efforts. Its sponsors were some 40 health provider organizations, state government agencies, professional associations and other groups. Each contributed manpower and money to meet the following objectives:

1. To promote the reasons and need for the development of comprehensive health planning programs on a local and area-wide basis in Iowa.

2. To assist Iowa communities and areas in the organization and establishment of health planning programs.

3. To provide technical assistance and staff consultation to communities and areas in assessing their particular health needs and developing programs to meet those needs.

4. To serve as a central coordinating agency for area-wide health planning programs in Iowa.

5. To serve as a partner and participant with the Office of Comprehensive Health Planning (OCHP) in the development of a Comprehensive Health Plan for Iowa.

Over the years the corporation worked to accomplish these objectives. Grants were received through the Office of Comprehensive Health Planning which materially assisted in hiring staff and paying travel costs to conduct numerous organizational meetings throughout the state.

(Please turn to page 229)

1973 SCIENTIFIC SESSIONS

Below are scenes at the Des Moines Airport March 29 as the Iowa Medical Society entourage prepared to enplane for the 1973 Scientific Session at Nassau, in the Bahamas. More than 250 members of the Society family participated in the successful five-day event.



EDUCATIONAL GRANTS FOR 1973 SCIENTIFIC SESSION

The Iowa Medical Society is pleased to acknowledge educational grants from the following organizations provided to support the 1973 IMS Scientific Program.

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Winthrop Laboratories
The Upjohn Company

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

$$I = \frac{E}{R}$$

Do you recognize this equation? If you reach far into your memory, you may recall Ohm's law, which states that the amount of current (I, amperes) flowing in an electrical circuit is proportional to the energy or electromotive force (E, volts) and inversely proportional to the resistence in the circuit (R, ohms).

What's my point? I recently attended a national workshop concerned with the diffusion of innovation in medicine, a workshop which attempted to formulate a strategy for studying the characteristics that promote the optimal diffusion or adoption of new medical treatments, procedures, equipment, or organizational structures. We know that some important advances are distressingly slow in being adopted widely. Others catch on too quickly, even before their worth is reasonably known —and how can we speedily abandon an entrenched method once it is shown to be worthless, or harmful?

As the conference proceeded, Ohm's law came to my mind for it seemed that innovation (I, adopting new or improved modes of behavior) was likewise proportional to the energy (E) invested in getting the word distributed, and inversely proportional to the resistance (R) of medical organizations (such as hospitals and societies), medical practitioners, and the public.

The energy refers both to the *kinds* of effort —journal articles, medical meetings, direct mailings, detail men, "professional gossip," in other words, all the modalities of continuing education—and to the quantity or vigor of the effort—for example, dollars spent, number of mailings, editorial urgings, third-party payer constraints, etc. Certain kinds of effort are probably more efficacious than others for certain kinds of medical innovations. Continuing education "specialists" need to state, or learn, which is which.

Resistance refers to the individual and group characteristics of the potential adopter. Questions to be answered are of this sort: Is increasing age associated with decreased adoption of new ideas and methods? Do physicians of some disciplines adopt more readily than others? Do solo practitioners adopt more (or less) readily than those in groups? How do hospital committees affect the rate of adoption? And so on.

The answers are now largely unknown. But I would challenge you to attempt a characterization of yourself. Are you an innovator, an early adopter, one of the bunch, or a laggard? Or if you are not totally consistent (who is?), what kinds of developments are you likely to adopt more readily, and which kinds are you more likely to resist? Do you tend to jump on the band wagon too early or too late? Which influences most successfully mold your personal behavior as a physician? What kind of continuing educational energy works best in getting *you* to adopt new innovations (that is, keep up to date)?

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.







T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.



AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy





PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3. In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling[2]. T_4 does convert to T_3, though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid®
(sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

FACTS:
Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name _____

Address _____

City _____ State _____ Zip _____

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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Morton Grove, Illinois 60053

Doctor's Business

by LARRY E. LEAVERTON

RETIREMENT—EARLY PLANNING

At a recent seminar a speaker emphasized that more people are thinking about retirement. He predicted by 1985 many will retire at age 40. It is doubtful many physicians will retire at this "peak" period in their career but we notice a greater number are thinking of retirement and are laying some groundwork.

The main ingredients in accumulating retirement funds are time and money. Both must work together to accomplish your goals. The earlier your plan is started the more time is available for the funds invested to compound. This point is illustrated by the following table. It assumes a $100 investment per month for various periods of years at various yields.

	YIELD			
Years	4%	6%	8%	10%
10	$14,400	$ 15,800	$ 17,400	$ 21,000
15	24,300	28,000	32,600	42,000
20	35,700	44,100	55,000	75,600
25	50,000	65,100	87,700	129,800
30	67,300	94,900	136,000	217,100
35	88,400	133,700	206,800	367,700

For the physician in a Self Employed Retirement Plan who has been investing $2,500 per year, this table may be easier to visualize.

Investment of $2,500 per year compounded:

	YIELD			
Years	4%	6%	8%	10%
10	$ 30,015	$ 32,950	$ 36,215	$ 39,845
15	50,060	58,190	67,880	79,430
20	74,445	91,965	114,405	143,185
25	104,115	137,160	182,765	245,865
30	140,210	197,645	283,210	411,235
35	184,130	278,585	430,790	677,560

How much accumulation is necessary to live comfortably at retirement? This will depend on the standard of living desired and the life expectancy at retirement, but it may be less than you think. Many people consider their present spending habits and attempt to put away more than enough; they become discouraged at the projection. At the time of retirement, personal living expenses will be reduced. The children will likely be on their own. The residence mortgage should have been liquidated along with other indebtedness. The high premium insurance program taken when the need for protection was great can be re-evaluated. Federal and State income taxes will be less due to reduced income. Remember—it is just the income from your accumulative retirement funds that will be taxed. Withdrawal of any of the principal is not. Exceptions are withdrawals of funds in a Self Employed Retirement Plan or Corporate Profit Sharing or Pension Plan where the tax liability has been deferred until withdrawal.

Tables are available to illustrate the total amount of retirement funds necessary to provide annual withdrawals of specific amounts for specific terms of years. The following table assumes a maximum of 25 years after retirement. Current estimates show a life expectancy of 15 years at age 65.

Annual Withdrawal	Funds Invested at Annual Rates of				
	4%	5%	6%	7%	8%
$10,000	$156,220	$140,940	$127,830	$116,540	$106,750
12,000	187,464	169,128	153,396	139,848	128,100
14,000	218,708	197,316	178,962	163,156	149,450
16,000	249,952	225,504	204,528	186,464	170,800
18,000	281,196	253,692	230,094	209,772	192,150
20,000	312,440	281,880	255,660	233,080	213,500
24,000	374,928	338,256	306,792	279,696	256,200
26,000	406,172	366,444	332,358	303,004	277,550

If you accumulated $230,000 at age 60, invested it at 6%, you could draw $18,000 per year until age 85. This would be supplemented by Social Security payments for some years.

Of primary importance in any retirement plan is the need to set realistic financial goals while there is still time.

PROPOSE FAMILY PRACTICE RESIDENCY PROGRAMS

ADEQUATE PHYSICIAN coverage for the State of Iowa has been and is a topic on the minds of concerned citizens from Clinton to Council Bluffs and from Leon to Northwood. When a need of this sort is identified it's best answered through conscientious and creative thinking and intelligent implementation of the resulting ideas.

Three important members of the Iowa health care team—the Iowa Academy of Family Physicians, the University of Iowa College of Medicine and the Iowa Medical Society—have brainstormed the manpower matter for a long period of time. In recent months a new approach has emerged. Leaders from these three groups have devised what they believe is a sound and practical way to brighten the medical manpower picture. The organizations are now petitioning the Iowa General Assembly for support of their idea.

What's the idea?

It calls for establishment through the University of Iowa of Community Family Practice Residency Programs in the larger cities in the state.

How will this help the manpower situation?

Studies demonstrate a larger percentage of physicians locate in or near the site of their residency. For example, an analysis* in 1971 produced the following statistics:

- **86% of those physicians who were born, attended medical school, interned and took a residency in a given state located there.**
- **78% of those physicians who were born and took a residency in a given state located there.**
- **72% of those physicians who attended medical school and took a residency in a given state located there.**
- **46% of those who were born, attended medical school and interned in a given state located there.**
- **32% of those who attended medical school and interned in a given state located there.**
- **29% of those who were born and attended medical school in a given state located there.**

What conclusions may be drawn from these statistics?

Obviously, the place of residency is most important in the conglomerate of factors used by physicians to select their practice sites.

What are the particulars on the plan espoused by the College of Medicine, the Academy of Family Physicians and the Medical Society?

Under this plan the College would be authorized to establish affiliated family practice teaching programs in cooperation with the medical profession, hospitals and clinics. Sites of the

IN THE PUBLIC INTEREST



Iowa
a place to grow

* From D. E. Yett and F. A. Sloan, Health Services Research Conference on Factors in Health Manpower Performance and the Delivery of Health Care, Chicago (12/9/71).

programs would be chosen by the Dean of the College of Medicine on the advice of a Family Practice Education Advisory Board. Among the site selection factors would be (1) geography, (2) population, (3) facilities, and (4) interest in medical education among the local physicians. Off-campus U. of I. medical faculty and local medical education directors would offer leadership to the accredited residency training programs.

Would medical graduates be available in sufficient numbers to fill the residencies?

Groundwork has been laid in Iowa with the establishment in 1971 of the Department of Family Practice within the College of Medicine. This and other factors seem to be influencing the career direction of medical students. For example, in 1966 27% of the freshman medical students designated family practice as their career choice. In 1972 this percentage had increased to 52. Obviously, the residencies would be open also to graduates of medical schools outside of Iowa, and hopefully a number would be attracted.

What Iowa communities might have the potential for Family Practice Residency Programs?

Active Family Practice Residency Programs now exist in Des Moines, Cedar Rapids and Iowa City. Programs are in the planning stage in Davenport, Waterloo, Sioux City and Mason City. Other Iowa communities with apparent potential include Dubuque, Council Bluffs, Clinton, Burlington, Fort Dodge, Keokuk and Ottumwa.

What supervision would the total effort receive?

As mentioned, a seven-member Family Practice Education Advisory Board would be created to advise the Dean of the College of Medicine. These individuals would be selected from different geographical areas and from different organizational involvements. The Advisory Board would provide counsel as to (1) the selection of areas of Iowa in which Family Practice Residency Programs are to be established; (2) how the funds appropriated by the General Assembly shall be allocated; and (3) the procedures for reviewing and evaluating the various programs.

What is the proposed schedule and cost to the State of Iowa for this proposal?

Under the timetable envisioned three residency programs would be operative in 1973-74; this would be expanded to eight by 1976-77. Advocates of the concept have suggested that an appropriation of just over two million dollars be allowed for the biennium starting July 1. The allocation of funds to a particular community-based program would not be permitted to exceed 50% of the total cost. This means funds from various other sources would be needed to support the program.

The funds allocated by the state could be used for salaries, stipends to the residents, initial construction or remodeling costs, equipment costs, etc. No subsidization of patient care costs is permitted from these state funds.

Has the idea received support?

Yes. Iowa Governor Robert Ray included the program among the items he has suggested as ones to be funded by the excess monies in the Iowa treasury at this time.

Nationally, in three years, 133 approved family practice residency programs have been created. Over 1,000 young doctors (300 will complete the three-year program in June) are currently training in these programs, double the number of a year ago. There are now departments or divisions of family practice in 64 of the nation's 105 medical schools. And over 40% of the new medical students nationally are selecting family practice as their career choice.

The American Board of Family Practice was created in 1969. To become certified by this body a physician must complete a three-year residency in family practice and pass an examination. He is also subject to re-certification in six years.

Iowa's future ability to deliver quality medical care to its citizens will depend on a variety of factors. A crucial one is the attraction of adequate medical manpower. The proposed Community Family Practice Residency Program is a means to that end.

Radiology Window

CASE NO. 11

During the past week you have seen two patients in your practice (a 38-year old white male and a 54-year old white female) each with chief complaints of dysphagia. These symptoms had their onset two and six weeks previously. Being an astute clinician you wisely ordered an esophagus x-ray with barium swallow on each patient. As you review the films your tentative diagnosis would be:

1. **Carcinoma of the esophagus.**
2. **Carcinoma of the larynx.**
3. **Aberrant right subclavian artery.**
4. **Foreign body in esophagus.**
5. **Normal deviation of the esophagus.**

(Please turn to page 230 for the correct diagnosis.)

This radiologic feature has been prepared and provided by members of the Radiology Department at Mercy Hospital in Des Moines. The co-authors are N. W. Irving, M.D., R. E. Hines, M.D., B. B. Augspurger, M.D., K. Tigrani, M.D., and B. Houle, a medical student.

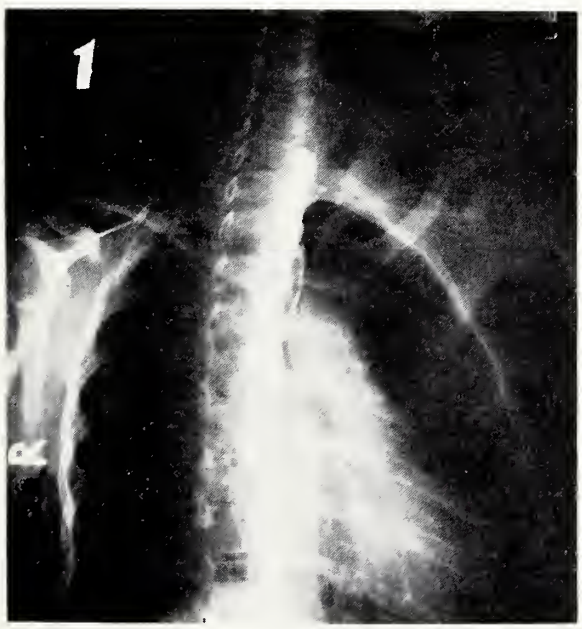


Figure 1

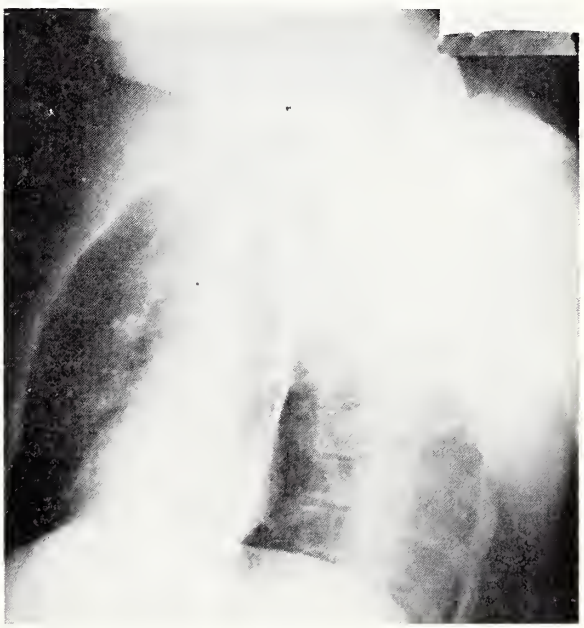


Figure 2

State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

RABIES

The three items which follow all concern rabies. The first summarizes the laboratory confirmed rabies in animals in Iowa in 1972. The second reviews the indications and procedures for pre-exposure immunization of man against rabies. The third describes the consultation available to physicians regarding patients with possible rabies exposure.

RABIES IN IOWA ANIMALS

Rabies in animals was reported by 73 Iowa counties in 1972. A total of 350 cases were recorded which is 33% higher than the 240 cases reported in 1971. All sections of the state were involved with somewhat fewer cases in the southwest. Since these reports refer to only laboratory confirmed cases they represent only a fraction of the actual incidence of the disease. For various reasons many obviously sick animals of various species suspected of having rabies are not submitted to a laboratory for examination and thus are not recorded.

As in previous years many more cases were reported in skunks than in any other species. All indications suggest that striped skunks serve as Iowa's principal reservoir of rabies.

Seven cases in dogs in seven different counties were reported in 1972 compared with 11 cases in 1971. None of these dogs had been vaccinated against rabies. Three of the cases were under 6 months of age, two were more than 3 years old and two were unknown.

State law requires that owners have their dogs vaccinated against rabies when the dogs reach 6 months of age. For maximum protection vaccination at an earlier age with a booster dose at 6 to 12 months of age is suggested.

PRE-EXPOSURE IMMUNIZATION

The relatively low frequency of reactions to duck embryo origin vaccine (DEV) has made it practical to offer pre-exposure immunization to persons likely to be exposed to rabies. Veterinarians, selected animal handlers, certain laboratory workers and other persons whose vocation or avocation may result in exposure to the disease should be considered for pre-exposure prophylaxis.

Two 1.0 ml injections of DEV given subcutaneously in the deltoid area one month apart should be followed by a third dose 6-7 months after the second dose. This series of 3 injections can be expected to produce neutralizing antibodies in 80-90% of the vaccinees one month after the third dose.

Persons who receive the pre-exposure vaccination should have serum tested for neutralizing antibody 3-4 weeks after the third injection. For this purpose a 5.0 ml blood specimen should be sent with dates of vaccine administration to the Virology Division, State Hygienic Laboratory, University of Iowa, Iowa City 52240. If no antibody is detected, booster doses should be given until antibody is detectable in serum drawn one month after each booster. Persons with continuing exposure should receive 1.0 ml boosters every 2-3 years.

When an immunized person with previously demonstrated rabies neutralizing antibody is exposed to rabies it is recommended that he receive 5 daily doses of vaccine plus a booster dose 20 days later. If it is not known whether an immunized person ever had antibody, post-exposure treatment should be identical to that for unimmunized persons.

RABIES CONSULTATION

Each year many patients present themselves to Iowa physicians with stories of definite or possible exposure to potentially rabid animals. To assist physicians in making decisions as to the best course of action, the Iowa State Department of Health has provided consultation when requested. In recent years this has been done through the mechanism of a "Rabies Board" composed of the physicians and veterinarian within the Department who are available at the time of a request. Normally, one individual gathers the information from the local physician. He then presents this to the other members of the board. The various factors are discussed and a decision is reached on the advice to be given and the reasons for it. The local physician is given the recommendation in a return telephone call and a follow-up written summary. The final decision of course remains with the local physician. We do feel the "Rabies Board" can render a service since it has an opportunity to review many situations and is familiar with the various factors that need to be considered.

Calls during working hours should be directed to 515/281-5424, 281-5605 or 281-5606. After hour and weekend calls should be directed to 515/281-5559.

IOWA MEDICAL MISCELLANY

(Continued from page 193)

HEALTH COMMISSIONER . . . IMS continues to oppose moves by some state officials to eliminate requirement that Iowa Commissioner of Health be a physician. A bill to allow this is in the hopper.

SPORTS MEDICINE . . . IMS Committee on Sports Medicine met April 25 with representatives of the Iowa High School Athletic Association to give preliminary consideration to a second conference for high school coaches and trainers and interested physicians. 1972 conference attracted 300 participants.

PSYCHIATRIC CARE . . . George Winokur, M.D., professor and head of the department of psychiatry at The U. of I. College of Medicine, met April 12 with the IMS Subcommittee on Psychiatric Care to discuss the University's psychiatric education program.

CHIROPRACTIC . . . IMS representatives appeared at April 5 public hearings on chiropractic at Iowa Statehouse. Reasons for opposing changes in the chiropractic practice act were presented.

PROFESSIONAL LIABILITY . . . Medico-Legal Committee supplemental report to IMS House of Delegates indicates 56 percent of the respondents to Committee survey said they felt their physician colleagues would participate in a Society sponsored malpractice program with benefits at least equal to present coverage.

HAWKEYE SCIENCE FAIR . . . Nearly 700 junior high and high school students had scientific exhibits at the 1973 Hawkeye Science Fair in Des Moines April 6 and 7. Iowa Medical Society and Scanlon Medical Foundation are sponsors of the annual event.

Conn, Rakel & Johnson: FAMILY PRACTICE

A new text for a new specialty. 75 authorities define community, behavioral and clinical medicine as it pertains to family practice. It's the first text geared to meet the needs of the practitioner and resident in the specialty, the generalist seeking a comprehensive reference in family care, or anyone preparing for certification in Family Practice.

This definitive text provides complete coverage of *family psychodynamics—management of the health care team—ecological medicine—psychopharmacologic agents—marriage, family, sexual and group counseling—schizophrenia—drug abuse—alcoholism*—plus 15 chapters on the clinical specialties in family practice.

No other book brings together so much information tailored specifically to the needs of the family physician and primary care specialist.

Edited by **Howard F. Conn**, M.D.; **Robert E. Rakel**, M.D., Prof. and Head, Dept. of Family Practice, Univ. of Iowa College of Medicine; and **Thomas W. Johnson**, M.D., Director, Div. of Education, American Academy of Family Physicians. *1093 pp., 379 figs. $29.50. February.*

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Journal Book Shelf

BOOK REVIEWS

ADVANCES IN ELECTROCARDIOGRAPHY, ed. by *R. E. Schlant*, M.D., and *J. W. Hurst*, M.D. (New York, Grune & Stratton, 1972, $24.75).

Thirty-two investigators assembled from three continents have contributed to this symposium. Invasive techniques, such as His bundle electrograms and atrial pacing, have contributed much in recent years to knowledge of cardiac electrophysiology, and this volume brings reports from many research frontiers.

This is not a book for the casual electrocardiographic interpreter. It is a collection of scholarly papers on current investigative activities; one contribution contains some 255 references to the current literature! Some of it is slow going, made none the easier by small type and reduced scale reproduction of illustrations, requiring a hand lens to see some of the detail. But it is solid meat, spiced occasionally by such sprightly writing as that of Thomas James with "Heuristic Thoughts on the Wolff-Parkinson-White Syndrome."

Cardiologists and electrocardiographers will find much that is provocative and stimulating in this volume.—*Herman J. Smith*, M.D.

THE MATERNAL PHYSICIAN, Second Edition (First Edition, 1818), by an American Matron, ed. by *Chas. E. Rosenberg*. (New York, Arno Press & The New York Times, 1972, $14).

This publication represents another reprint of an old treatise in the series of medicine and society in America. Written by an anonymous matron, the book is a treatise on the nurture and management of infants from birth until two years of age. The stated qualification of the author is 16 years of experience in the nursery. She draws upon the teachings of the great medical writers of the day—William Buchan, Michael Underwood, Hugh Smith and George Wallis. The student of pediatrics and medical history will find this review interesting and enjoyable.—*M. E. Alberts*, M.D.

LABORATORY MEDICINE, HEMATOLOGY, Fourth Edition, ed. by *John B. Miale*, M.D. (St. Louis, C. V. Mosby Company, 1972, $27.50).

This book appears to be well organized, with abundant black and white illustrations. The quality of the illustrations is excellent, although there are no color photographs. Of great interest to practicing hematologists will be the case studies which include illustrations and simple reading for history and physicals, results of tests and discussion. If more information is needed the topic can then be easily referred to with more reading for diagnosis and treatment. The only criticism is that the reference articles are not arranged in the conventional method. It will be difficult and confusing for readers to correlate certain facts and statements in the book with reference articles listed in the back. The material is complete and well presented. It is recommended to practicing hematologists, clinical pathologists and laboratory technologists.—*Joseph Song*, M.D.

PRACTICAL AUTOMATION FOR THE CLINICAL LABORATORY, Second Edition, ed. by *Wilma L. White*, B.A., F.A.I.C., *Marilyn M. Erickson*, B.S., and *Sue C. Stevens*, B.A., M.A., Ph.D., F.A.I.C. (St. Louis, C. V. Mosby Company, $22.50).

This book is of interest only to those who deal with the technical aspects of laboratory medicine. It is descriptive, primarily by manufacturers, of the theory and mechanics of the automated equipment they produce. No attempt is made by the editors to evaluate the down time, efficiency, accuracy, operating expense or other areas of information which might be of interest to a prospective buyer. With the rapid changes in technology and large number of new instruments being marketed continually this book is already out of date.—*Wallace Rindskopf*, M.D.

ELECTRONICS FOR MEDICAL PERSONNEL, by *Edward J. Bukstein*. (Indianapolis, Howard W. Sams & Co., Inc., 1972. $4.95).

This book has 140 easily read pages. It is divided into 15 chapters, with an explanation of the language of electronics, biomedical recording systems, and a very complete description of heart monitoring, blood pressure monitoring, fetal monitoring, electrical safety, telemetry and defibrillators. There is a short chapter on the use of digital computers.

The book will provide medical personnel with a better understanding of the electronic principles governing the electronic equipment used in hospitals and medical centers. Material in the book will aid medical personnel in avoiding situations that could produce faults or misleading indications which could prove hazardous. It contains information to help the tech-

nician understand normal and abnormal behavior of the equipment and the signals involved, both from the equipment and the patient. The book is rather elemental as concerns electric physiology and the function of the electrocardiograph, but does contain much useful information for the physician on the operation of much of the monitoring equipment, and in the physics of telemetry and computers.—*Paul From,* M.D.

PEDIATRICS, Fifteenth Edition, ed. by *Henry L. Barnett,* M.D., and *Arnold H. Einhorn,* M.D. (New York, Appleton-Century-Crofts, 1972, $26.50).

This volume represents the efforts of numerous contributing authors. It is the fifteenth edition of DISEASES OF INFANCY AND CHILDHOOD originated in 1896 by the late L. Emmett Hall. The book (over 2000 pages and nearly three inches thick) approaches being cumbersome. Considerable rewriting has been done in this edition with new authors on immunologic principles, consideration of the nose, throat and ears, congenital malformations and drug abuse. This book remains an excellent, time-honored reference to the diseases of infants and children.—*M. E. Alberts,* M.D.

CURRENT CONCEPTS IN RADIOLOGY, ed. by *E. James Potchen,* M.D. (St. Louis, C. V. Mosby Company, 1972, $24.75).

With the help of 19 distinguished co-authors, Dr. Potchen has assembled selective topics important to the practicing radiologist and radiologist in training for optimal application of information to patient care.

Each author presents his topic in a form that makes interesting and understandable reading. Even the Fourier transformation becomes meaningful to those whose mathematics like mine end in long division. Chapters on the Radioisotopic Detection of Tumors, The Selective Renal Arteriogram in Man, and Concepts of Injection Technique, obviously reflect the expanding frontiers of radiology.

This text is so timely and scientifically current it will soon require updating. Indeed many of the chapters are almost progress reports on what is new in the assigned field. The text does suffer from some typographical errors, and I suspect it may have been proofread by a non-physician.

This text will be invaluable to the radiologist in training and the busy practicing intellectually alert radiologist who is trying to stay abreast with the frightening accumulation of the new scientific basis of his practice.—*Donald C. Young,* M.D.

HANDBOOK OF MEDICAL TREATMENT, Thirteenth Edition, ed. by *Milton J. Chatton,* M.D. (Los Altos, California, Lange Medical Publications, 1972, $6.50).

This is the thirteenth edition of this "take with" manual of therapy. It devotes only the briefest attention to diagnostic data, in the interest of conserving space for discussion of new drugs and other therapeutic modalities.

A compendium by 19 authors, it suffers from the common uneven quality of presentation characterizing such joint efforts. It is, however, generally up to date, with discussions of such recent developments as aorto-coronary bypass surgery and the methadone treatment of heroin addiction. There are those who will take exception to such statements as the one that isoproterenol increases myocardial contractility and cardiac output (p. 8), or that "pharmacologically, alcohol and marihuana can be considered the social drugs of different generations." (p. 591)

There are compact but valuable sections on the treatment of shock and electrolyte disturbances and on newer concepts of cancer chemotherapy.

The pocket-sized volume suffers from some unevenness of printing quality, with some pages so faint as to make reading difficult, particularly when combined with the small type size. In over-view, it is a valuable handbook for the house officer or emergency room physician, or for the harried and hurried office practitioner who needs a quick refresher concerning a problem in therapy.—*Herman J. Smith,* M.D.

WELL DONE, HPCI

(Continued from page 221)

The first full time HPCI director was Richard Rix and James Stewart came aboard in August of 1969. Both men worked diligently to get the state organized with the help of many volunteer workers, not to mention the able assistance of many board members who served without pay.

For the past three and one-half years, Jim Stewart and staff have labored conscientiously to accomplish HPCI objectives. Their efforts have been productive. Each of the 16 districts in Iowa now have a health planning agency serving the area. Some are more heavily populated and hence, more highly developed.

HPCI organized the Joint Session of Area-Wide Health Planning Councils. This unit has done much to lift up the level of planning through the free exchange of ideas and programs. It is a continuing enterprise.

The orgininal purposes of HPCI have been pretty well achieved and there is satisfaction in knowing this. Those associated with HPCI have expressed sincere thanks to all those people who made the organization an effective and respected organization. There will always be work to do at the local level to improve the health care delivery system. We have every confidence their objectives will be accomplished through the active cooperation of the Office of Comprehensive Health Planning. Farewell to HPCI—a job well done.

RADIOLOGY WINDOW

(Continued from page 225)

CASE NO. 11

The correct diagnosis in each is right aberrant subclavian artery.

This anomaly, which is one of the vascular ring anomalies, is a result of the abnormal disappearance of the right fourth aortic arch. The aberrant right subclavian does not communicate with the ascending aorta but instead arises as the last branch of the aortic arch. It then courses upward to the right and thereby causes an imprint upon the right posterior lateral wall of the esophagus at the level of thoracic 3 or 4. The defect is above the level of the aortic knob and is best seen in the posterior anterior and left anterior oblique projections.

Generally this anomaly is asymptomatic and does not require therapy. However, with increasing age and decreasing elasticity of the arteries, signs and symptoms may become evident. Dysphagia lusoria ("jest of nature") was first described by Bayford in reference to this anomaly. The following symptoms are indications for surgical intervention (which is the only form of treatment for vascular rings), dysphagia, dyspnea from tracheal pressure and recurrent aspiration with tracheitis.

Previous surgical approaches were: (1) thoracotomy, but this occasionally resulted in a Subclavian Steal Syndrome, and (2) Sydney's method of reimplanting the subclavian into the right carotid. A more recent approach has been described through a low cervical incision with dissection on both sides of the trachea and esophagus. This allows isolation, division and removal of the artery from behind the esophagus. The subclavian is then implanted into the carotid. This approach eliminated the need for a thoracotomy; however, care must be taken not to injure the recurrent laryngeal nerve.

DISCUSSION

These two cases illustrate the value of a barium examination of the esophagus in establishing the etiology of dysphagia. The opaque media used can vary from a contrast material identical to that used in upper gastro-intestinal studies, to a more thick creamy consistency. Pledgets of cotton saturated with barium may be used when a foreign body, such as a fish bone, is suspected. Fluoroscopy, radiography and occasionally cinefluorography are the technical procedures used. As in these cases, angiography may be necessary for positive diagnosis. In angiography, as demonstrated in Figure 4, a slight alteration in obliquity may obscure the origin of an aberrant subclavian.



Figure 3



Figure 4

About IOWA Physicians

The following Burlington physicians have been elected 1973 officers of Des Moines-Louisa County Medical Society: **Dr. F. D. Winter,** president; **Dr. H. B. Tjaden,** president-elect; **Dr. J. J. Kivlahan,** secretary; and **Dr. R. E. Kellogg,** treasurer. . . . **Dr. John Doran,** Ames, was guest speaker at recent meeting of Hardin County Nurses' Association. Dr. Doran's talk was entitled, "On Being a Woman." . . . **Dr. Herman A. Hein,** Dubuque pediatrician, has been named director of newly established statewide perinatal care program. Dr. Hein will arrange educational programs for physicians and nurses concerned with maternal and newborn care in Iowa hospitals and provide consultation to hospitals. . . . **Dr. Walter Block,** Cedar Rapids, was guest speaker at recent meeting of Ottumwa Association for Children with Learning Disabilities. Dr. Block and two staff members of Cedar Rapids Child Evaluation Clinic explained how clinic was established and how children with learning disabilities are diagnosed. . . . **Dr. C. D. Fenton,** Bloomfield physician for 40 years, retired from active practice in February. A 1931 graduate of U. of I. College of Medicine, Dr. Fenton came to Bloomfield after interning at W. A. Foote Memorial Hospital in Jackson, Michigan. Dr. Fenton and his wife presently reside in Atlanta, Georgia, but plan to return to Iowa this summer.

Drs. Ruby Cureg, Charlotte Fisk and **Everett A. Nitzke,** Des Moines pediatricians, have been selected by the American Academy of Pediatrics to evaluate the medical aspects of Head Start programs in 2,000 communities. . . . **Dr. John C. Justin,** Mason City, was guest speaker at recent meeting of Mason City Chapter, American Association of Medical Assistants. Dr. Justin spoke on rheumatic fever. . . . **Dr. Reginald R. Cooper,** professor of orthopaedic surgery at U. of I. College of Medicine, is new president-elect of Orthopaedic Research Society. Also, Dr. Cooper has been appointed reviewer for joint Accreditation Committee of American Board of Orthopaedic Surgery and AMA, and has been elected to one-year term on board of directors of American Academy of Orthopaedic Surgeons; membership in American Orthopaedic Association and membership in Canadian Orthopaedic Association. . . . **Dr. L. C. O'Toole,** LeMars, was named "outstanding citizen of the year" at 55th annual meeting and banquet of LeMars Chamber of Commerce. Dr. O'Toole, who has practiced medicine in LeMars since 1929, was cited for his distinguished service to community. . . . **Dr. L. J. Kirkham,** Mason City, served as instructor at recent seminar offered by North Iowa Area Community College for diabetics and their families.

Dr. James Kimball, Osceola, participated in panel discussion on hospital and medical costs sponsored by Clarke County Hospital Auxiliary. Dr. Kimball spoke on medical fees and care. Merle Libby, IMS Blue Cross-Blue Shield fieldman, discussed Blue Cross and Blue Shield policies. . . . **Dr. Mark Messingham** will join **Drs. James H. Coddington** and **M. L. Northup** in practice of medicine at Humboldt in July. A graduate of U. of I. College of Medicine, Dr. Messingham is presently completing postgraduate training at Haag Memorial Hospital in Newport Beach, California. . . . **Dr. J. T. May** has resigned as superintendent of Cherokee Mental Health Institute. Dr. May plans to continue to reside in Cherokee. . . . **Dr. Robert Donlin,** Harlan, has been named director of newly formed alcoholic rehabilitation center at Iowa Methodist Hospital in Des Moines. Dr. Donlin plans to continue his family practice of medicine in Harlan and will commute to Des Moines.



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Dr. James Habermann, Fort Dodge pathologist, discussed different types of cancer at recent meeting of newly organized Task Force Uterine Cancer Control Committee in Humboldt. Project of committee is Pap test for every woman in Humboldt County 20 years and older by 1976. . . . **Dr. Gary Olson,** who will join the Buena Vista Clinic in Storm Lake this summer, was inducted into Iowa Basketball Hall of Fame at 1973 Boys State Tournament in Des Moines. Dr. Olson holds IHSAAA record for most free throws by one player in one game, 23. He was twice named to All-State High School team and while attending University of Iowa was named to second All Big Ten academic team. Dr. Olson received M.D. degree at U. of I. College of Medicine in 1971 and for two years has been serving internship and residency in family practice at Broadlawns Polk County Hospital in Des Moines. . . . **Dr. John R. Doran,** Ames, was guest speaker at recent Webster City health program sponsored by local Council of Parent Teacher Associations. Dr. Doran spoke on human sexuality.

Dr. Robert T. Gray, medical director of Iowa Soldiers Home in Marshalltown, attended first Appalachian Conference of Physical Activity in Aging at Charleston, West Virginia. The group is concerned with physical conditioning and how it affects the aging population. . . . **Dr. Charles A. Fangman,** Carroll, Community Service Program chairman for Carroll County Chapter of American Cancer Society, was recent featured speaker on local radio program entitled "What's Your Opinion Program." . . . **Dr. R. A. Sedlacek,** Cedar Rapids, was guest speaker at fourth in a series of interdenominational men's Lenten luncheons in Cedar Rapids. Dr. Sedlacek's topic: "Here Comes Death —Are You Ready?" The six-week series of Lenten luncheons is sponsored by the Catholic laymen's club, Churches United and the Metropolitan Area YMCA. . . . **Dr. Leo H. Kuker,** Carroll, is new president of the American Society of Abdominal Surgeons. He was elected at the organization's 14th annual clinical congress in Honolulu, Hawaii. Dr. Kuker presented a paper on biliary tract surgery and common duct stones at a congress postgraduate course and moderated a panel on surgery of the aged.

Dr. Warren Wulfekuhler, Mason City urologist, discussed role of private physician and local treatment facilities for venereal disease at recent VD Seminar in Mason City. **Dr. Arnold M. Reeve,** Iowa Health Commissioner, gave an overview of the problem, including prevalence of the disease and medical facts. The seminar was sponsored by St. Joseph Mercy Hospital and Iowa State Department of Health. . . . **Dr. L. K. Berryhill,** psychiatrist and medical director of North Central Iowa Mental Health Center in Fort Dodge, was main speaker at recent one-day workshop for law enforcement officers at Mental Health Institute in Cherokee. Theme of the workshop was "The Law Enforcement Officer and Psychiatric Emergencies." . . . **Dr. Walter M. Block,** Cedar Rapids, discussed management of children with seizures and hyperkinetic behavior at recent meeting of Iowa Chapter, Council for Exceptional Children, in Des Moines. . . . **Dr. John Huston, Jr.,** Cedar Rapids, was named Fellow in American College of Radiology at College's 50th annual meeting in San Francisco, California. . . . **Donald L. Taylor,** Executive Vice President of Iowa Medical Society, has been named to a consulting task force on evaluation of programs for American Medical Association's advisory committee on Professional Standards Review Organizations.

Dr. L. W. Van Voorhis, Sioux City, is medical profession chairman for Woodbury County Cancer Crusade. . . . At recent meeting of Council Bluffs Board of Health, **Dr. Rosalie Neligh** was elected vice chairman and **Dr. Arthur Sciortino,** secretary. Both are Council Bluffs physicians. . . . **Dr. Eugene L. Wiemers,** director of Clinical Services at Cherokee Mental Health Institute, has been named interim superintendent. **Dr. J. T. May** resigned this post in March. Dr. Wiemers joined MHI staff in 1950 as Clinical Director of Extramural Psychiatry and is presently Associate Director of Training and Research and Director of Clinical Services. . . . **Dr. Jose Martinez,** Council Bluffs urologist, and member of Kidney Foundation of Iowa Medical Advisory Board, was guest speaker at recent Council Bluffs Foundation Conference. . . . **Dr. George H. West,** Mason City, has been elected to board of trustees of North Iowa Medical Center Planning Board Corporation. Dr. West will represent Cerro Gordo County.

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DEATHS

Dr. Milford E. Barnes, 89, professor emeritus of U. of I. College of Medicine and former director of State Hygienic Laboratory, died March 7 at nursing home in Toledo, Ohio. Dr. Barnes received M.D. degree at Rush Medical College and completed postgraduate work at London, England, School of Tropical Medicine and Johns Hopkins School of Hygiene and Public Health. In addition to directorship of State Hygienic Laboratory, Dr. Barnes served as professor and head of U. of I. Department of Hygiene and Preventive Medicine and as director of University Department of Health. He was life member of Iowa Medical Society and American Medical Association.

Dr. Fred L. Knowles, 84, of Fort Dodge, who won international acclaim with new method of treating hip fractures, died at Mercy Hospital in Fort Dodge February 13. A 1920 graduate of U. of I. College of Medicine, Dr. Knowles served his internship at Children's Hospital in Iowa City and residency at St. Luke's Hospital in Chicago. He began his practice of orthopedic surgery in Fort Dodge in 1924. Dr. Knowles

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was a charter member of American Orthopedic Academy. He had served as president of Iowa Orthopedic Society, Webster County Medical Society, Lutheran and Mercy Hospital staffs; vice president of Iowa Medical Society; member of International College of Surgeons and North Central Orthopedic Society.

Dr. I. U. Vangsness, 84, long time Sioux City physician, died March 14 in a Clearwater, Florida hospital. Dr. Vangsness received the M.D. degree at Northwestern University in 1913 and served his internship at City Hospital in St. Louis. He established his medical practice in Sioux City in 1921 and retired in 1961. Dr. Vangsness was a Fellow in American College of Surgeons, member of Iowa Medical Society and American Medical Association.

Dr. William B. Chase, Jr., 66, of Des Moines, died at his home March 23. A graduate of U. of I. College of Medicine, Dr. Chase had practiced general medicine and surgery in Des Moines since 1932. He was on the staffs at Iowa Lutheran, Mercy and Iowa Methodist Hospitals, member of Iowa Medical Society and American Medical Association.

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Medical Assistants

by TENORA MEYER, CMA

1973 LEADERS

Our Chapter Officers for 1973:

Cedar Rapids, Linn Co.: *President: Peggy Mulvehill, President-Elect: Velma Goettel, Vice-President: Charlotte Gibney, Secretary: Von Lillios, Treasurer: Margaret Porter*

Davenport, Scott Co.: *President: Jean Gold, President-Elect: Arlene Rollston, Vice-President: Elizabeth Swenson, Secretary: Roma Brown, Treasurer: Irma Frohboese*

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Sioux City, Woodbury Co.: *President: Caroldean Magden, Vice-President: Winnie Donovan, Secretary: Celia Dermit, Treasurer: Frances Hanson*

Waterloo, Black Hawk Co.: *President: Florence Henry, President-Elect: Charlotte Lewis, Vice-President: Emma Morgensen, Secretary: Cynthia Keegan, Treasurer: Sandra Hayungs*

Jeanne Greene, of Davenport, was chosen among nine AAMA Trustees to be interviewed by the AMERICAN MEDICAL NEWS. Interviewed with Jeanne were Betty Lou Willey, AAMA Vice President, Port Huron, Michigan, and Laura L. Lockhart, AAMA Speaker of House of Delegates, Akron, Ohio. The interview feature was printed in the January 22 issue, and included views on the qualifications and duties of a medical assistant, certification and doctor-medical assistant relationships.

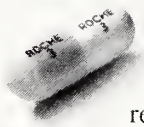
Jeanne explained that first thoughts of the certification examination "left her cold" because of her long tenure as a medical assistant and a feeling there "wasn't much she could gain." After receiving her certification, however, she was happy she made the effort and proud of her accomplishments. When asked about doctor-employee relationships, Jeanne said, "I respect him as a man and I cherish him as a friend; for example, I would have no hesitation about asking him for advice if there were something on my mind but still our lives are distinctly separate and that's the way it has to be."

The Mason City Chapter hosted 25 medical assistant students of NIACC at its March meeting. The members presented a skit entitled: "Take a Good Look at Yourself." Starring as medical assistants were Jo Popenhagen, Bonnie Tagesen and Jane Ewald with Arlys Wirtjes as the physician. In the skit medical assistants, a few years out of training, had allowed their office habits to slip resulting in poor patient relationships. A previously patient physician-employer finally sent them off to a Medical Assistant Workshop with an ultimatum to develop better office techniques. The second act showed an efficient medical office with the medical assistants demonstrating an awareness of their professional responsibilities after attending the workshop. It was the consensus of both doctor and medical assistants that joining an organization of medical assistants which provides in-service education and association with other medical assistants is definitely desirable. The skit was entertaining and both Jo and Bonnie agreed Act I was easy as we all have a tendency to make light of our responsibilities, while buckling down takes a little more "go-go."

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

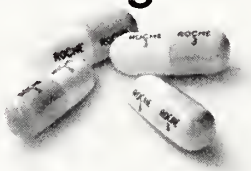
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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Valium®
(diazepam)

To help you manage excessive psychic tension

President's Page



I was tremendously impressed with the April meeting of the House of Delegates. We had a good attendance, and there was a real spirit of frankness. I was impressed with the broad understanding of the various complex issues of the day, e.g., component billing, termination of pregnancy, UCR, etc.

The proposed reapportionment of the IMS House of Delegates produced some spirited discussion. This important matter is worthy of our most careful consideration. On an extremely close vote, the House of Delegates instructed the Standing Committee on Articles of Incorporation and By-laws to draft language to permit a revamping of the delegate selection process. This language is to be considered at the scheduled fall (regular) meeting of the House. In the interval full discussion of the recommendations which have been made to date is strongly encouraged. We hope county medical societies will evaluate the proposals carefully. Reapportionment is important to all medical sectors, rural, urban, education, etc., and is deserving of our close analysis.

Conscientious advance study of the proposition will enable us to come together in October to debate intelligently and decide wisely.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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IOWA Medical Miscellany

SCANLON ANNIVERSARY . . . Twentieth anniversary of the Scanlon Medical Foundation/Iowa Medical Society was noted in Foundation's 1973 Report to IMS House of Delegates. Report also advised of record participation (41 students) in the medical student loan program. From April to April $56,055 was loaned to Iowans attending medical school. Concern was expressed over the Foundation's ability to maintain this level of support with only limited additional resources available. J. F. Bishop, M.D., Davenport, is new president of the Foundation.

'74 SCIENTIFIC SESSION . . . 1974 IMS Scientific Session will occur in Iowa City in early to mid-April. Invitation extended by Society President Flocks on behalf of John Eckstein, M.D., Dean, College of Medicine, has been accepted.

MEDICAL GRADUATES . . . Congratulatory letters were sent last month by Society President R. H. Flocks, M.D., to the 144 seniors who received medical degrees May 26. Dr. Flocks offered support of the Society's Physician Placement Service to any of the graduates.

ANNUAL MEETING HIGHLIGHTS—Highlights of the 1973 Annual Meeting of the IMS House of Delegates were summarized in a May 7 News Bulletin. Complete House proceedings will appear in the July issue of THE JOURNAL. Briefly, the House approved a guideline statement on termination of pregnancy (See Page 248) . . . authorized a committee of the House to study the Society's fiscal status and make specific recommendations at the fall session planned October 12-14 . . . praised and urged continuance of the good rapport with Blue Shield . . . expanded from one to three the number of alternate delegates to AMA . . . instructed the Standing Committee on Articles of Incorporation and By-Laws to prepare language to reapportion the House (based on one delegate for each 15 members, or major fraction, within a district) and to have this ready for further consideration at next session of the House . . . urged Medico-Legal Committee to continue its appraisal of professional liability matters . . . authorized appointment of a special committee to study quality of medical care in state correctional institutions . . . recommended greater coordination of the medical profession's legislative efforts . . . endorsed the AMA Medicredit proposal . . . revised IMS Life Membership requirements . . . invoked attendance requirements for IMS councilors . . . requested further study of a "statewide customary (fee) profile" by specialty . . . sustained the 5-component billing system . . . protested invasion of medical practice by certain "family planning projects" . . . approved entry on IMS dues billing statement for voluntary contributions to the Scanlon Medical Foundation/IMS . . . encouraged all Iowa physicians to join the Iowa Foundation for Medical Care.

PSRO SESSION . . . Day-long conference on PSRO's is to be presented June 6 under sponsorship of Iowa Foundation for Medical Care at the Savery Hotel in Des Moines. Hospital chiefs of staff and utilization review chairmen have been urged to attend the meeting with hospital administrators.

COMMITTEE APPOINTMENTS . . . Society President R. H. Flocks has invited several hundred IMS members to serve on the approximately 50 organizational committees in 1973-74. Invitational mailing was sent in May.

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THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 63 No. 6
JUNE 1973

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The Question Box



by L. W. SWANSON, M.D.

Dr. Swanson is the senior IMS delegate to the American Medical Association and will represent Iowa physicians this month at the AMA Annual Meeting. He practices internal medicine in Mason City. Serving with Dr. Swanson as Iowa delegates to the AMA this month will be H. J. Smith, M.D., and E. M. Smith, M.D., both of Des Moines. C. E. Radcliffe, M.D., Iowa City, is the alternate delegate.

How would you characterize the AMA House of Delegates?

The AMA House of Delegates includes 250 physicians who represent the state medical societies, the various AMA specialty sections and the various specialty societies. It covers all physician interests quite effectively. Currently, representatives of the medical student, intern and resident organizations are being added to the House of Delegates with full voting privileges. This House meets twice yearly for four or five days to consider all problems of medicine brought to its attention.

Does this policy-making process at the national level effectively reflect grass-roots physician thinking?

The study and the hearings conducted by the AMA House do effectively reflect local physician thinking. Any physician is welcome to make himself heard before the reference committees. Many policy decisions are based on the opinion and knowledge offered by AMA members to those physician delegates who serve on the reference committees and who prepare the reports to be acted on by the House. In this way all AMA members have an effective means of voicing their opinion if they wish to do so.

Is it possible for a smaller state such as Iowa to have its proposals considered and its opinion heard?

Iowa's resolutions to add to or change AMA policy have regularly been heard and considered and in many cases adopted. In my years as a delegate our small delegation has frequently solicited the support of other delegates for our ideas and accomplished their adoption. You will recall we successfully secured the election of Iowan Dr. Donovan F. Ward as AMA president, which certainly proves our state has been well represented and thoroughly heard.

The Annual Convention of the American Medical Association will occur at the Americana Hotel in New York City from June 23 to 28. Sixty-five reports and approximately 100 resolutions will be considered by the AMA House of Delegates. Russell B. Roth, M.D., Erie, Pa., will assume the AMA presidency. Raymond T. Holden, M.D., Washington, D. C., and Malcolm C. Todd, M.D., Long Beach, Calif., are nominees for president-elect.

What do you see as the prineipal issues in the session this month?

The long range planning proposals of the special AMA committee on this subject are to be reported in June. This and the current development of PSRO's will be two of the most discussed subjects at the June meeting. Your Iowa delegates will do their best to represent the views of Iowa physicians. To do this properly the Iowa AMA delegates participate regularly in the discussions of the IMS Executive Council as well as the annual meeting of the IMS House of Delegates.

Termination of Pregnancy

The following guideline statement which concerns the termination of pregnancy was approved April 30 by the Iowa Medical Society House of Delegates. The statement was assembled by the IMS Subcommittee on Maternal and Child Health in collaboration with officials at The University of Iowa College of Medicine. Much of the content of the statement is drawn from material approved by the American College of Obstetricians and Gynecologists.

The statement is intended for the reference use of local medical staffs and supplements the existing IMS policy in this area. It is prepared in light of the January decision of the U. S. Supreme Court to lift restrictions on a woman's right to a physician-performed abortion during the first three months of pregnancy.

The only modification made by the House of Delegates in the statement as presented by the Subcommittee was to reinforce the passage which declares that no physician or supporting personnel, or hospital . . . should be required to be involved in these procedures.

Pregnancy termination is a surgical procedure. For its performance adequate facilities, equipment and personnel are required to assure the highest standards of patient care. Pregnancy termination should be performed only by physicians who are qualified to identify and manage the complications that arise from the procedure.

First trimester abortions (up to 12 weeks gestational age) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State Department of Health.

Pregnancy termination beyond the first trimester should be performed in a hospital. It is hoped that the majority of terminations of pregnancy would be done under 12 weeks and only a limited number between the 12th and 20th weeks.

From the end of the 20th week until the onset of fetal viability (normally between the 24th and 28th week) pregnancy termination would best be done only for medical or genetic indications. Beyond the period of viability termination should be subject to the approval of a Hospital Termination of Pregnancy Committee and only when the action, based upon appropriate judgment, is necessary for the preservation of the life or health of the pregnant woman.

Facilities for the performance of first trimester terminations should include appropriate surgical, anesthetic and resuscitation equipment. In addition the following should be provided:

1. Verification of the diagnosis and duration of pregnancy.
2. Preoperative instructions and counselling.
3. Recorded preoperative history and physical examination, particularly directed to identification of pre-existing or concurrent illness or drug sensitivity that may have a bearing on the operative procedures or the anesthesia.
4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.
5. Prevention of Rh sensitization.
6. A receiving facility where the patient may be prepared and receive preoperative medication and observation prior to the procedure.
7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia

(Please turn to page 259)

1973 SESSIONS OF IMS HOUSE OF DELEGATES



ANNUAL MEETING SCENES—Upper left, S. P. Leinbach, M.D., Belmond, left, presents Ben T. Whitaker teaching award to Carroll B. Larson, M.D., professor and head of U. of I. department of orthopaedic surgery. Upper right, Ronald Saf, Des Moines, receives John F. Sanford Award from President Lister, M.D. Upper middle left, President Lister admires with Dr. and Mrs. Donovan Ward, Dubuque, portrait of the former AMA president given the Society by the Ward family. Upper middle right, R. L. Wicks, M.D., presents 1973 Merit Award to Elmer M. Smith, M.D., Des Moines. Lower middle left, Reference Committee on Articles and By-laws, standing, G. T. Schmunk, M.D., Clinton, and F. M. Ashler, M.D., Hamburg; seated, D. A. Bovenmyer, M.D., Davenport; W. T. Shultz, M.D., Marshalltown, and L. J. O'Brien, M.D., Ft. Dodge. Lower middle right, three new IMS Life Members and two wives, from left, Mrs. and Dr. J. O. Eiel, Osage, C. A. Sones, M.D., Des Moines, and Dr. and Mrs. H. E. Stroy, Osceola. Lower left, Reference Committee on Reports of Officers, from left, J. H. Coddington, M.D., Humboldt; D. O. Newland, M.D., Des Moines; R. A. Sautter, M.D., Mt. Vernon; H. M. Perry, M.D., Bloomfield, and R. J. Dawson, M.D., Estherville. Lower right, IMS Board Chairman J. F. Bishop, M.D., Davenport, left, visits with Dr. and Mrs. George Martin. Dr. Martin is president of the Minnesota Association.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

". . . SOOTHED AND SEDATED BY THE SUSURROUS SOUND . . ."

"Continuing medical education is a scholarly way of life whose sole purpose is the ultimate provision of constantly improving high-quality patient care." This fine quote is from Donald H. Williams, M.D. (A Taxonomy of Continuing Medical Education Endeavor, Canad. Med. Assn. J. 96:1040). He identifies medicine as a *profession* on the basis of a high level of conscience and ethical conduct, and upon scholarliness. The present impetus to renewed scholarly activity among practitioners, of course, derives from the weight of new scientific discoveries, plus the pressure of increasing public interest in the competence of physicians.

Dr. Williams' taxonomy describes five categories of activity, bound together into an indivisible unit by self-learning. All five are needed, but he ranks them in order of decreasing importance: (1) the habit of planned daily reading and study in a home library-sanctuary as an integral part of a physician's workday, *plus* (2) day-to-day informal and formal colleague association and consultation in patient care, *plus* (3) the periodic return every three to five years for at least three months of intensive study in the teaching hospital, *plus* (4) attendance at scientific sessions of learned professional societies, *plus* (5) attendance at short courses which must include pre- and post-course readings in the home library-sanctuary.

What will you have accumulated with a year's investment of an hour a day for reading? The equivalent of more than 45 full working days of eight hours each! "This is like adding one-and-a-half months of productive living to every year of life!" Such effort is to accomplish the *identification* of new information, the *reinforcing* of previously acquired essential knowledge, and the *discarding* of that no longer relevant to the good care of patients.

The "sabbatical must" of three months at a teaching center will strike most readers as the least obtainable part of this package. Does it seem more possible in your practice if divided into one or two weeks every one or two years? Whether providing one or two days, as in our In-House Conference, or longer individualized traineeships, the University of Iowa College of Medicine stands ready to help you. Identify your needs, and let's talk about them.

Although granting the great value of "short-course galvanic stimulation," Dr. Williams counts it as least important in his taxonomy via this glorious alliterative description: "Often a short course appears to be a 'pithed frog' exercise devoid of cerebration in which, hour after hour, row upon row of satiated, somnolent physicians are soothed and sedated by the susurrous sound of lengthy presentations intoned from a podium." To avoid this sorry state is one of my personal foremost goals in continuing education program planning.

Is your own continuing education planned systematically? If so, how closely does it approximate the ideal suggested by Dr. Williams? I conclude with another quote from this eminently quotable article: "The threatening goad of conditional licensure may frighten and coerce some obsolescent physicians into studious ways, but let it be said and underlined that compassion and a sense of trust for patients have been, are, and always will be the only enduring and effective forces that move a good physician to be a life-long learner on behalf of his trusting patients."

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

1973 SESSIONS OF IMS HOUSE OF DELEGATES



ANNUAL MEETING SCENES—Upper left, IMS officers, seated, R. L. Wicks, M.D., Boone, president-elect; J. F. Bishop, M.D., Davenport, board chairman, and R. H. Flocks, M.D., Iowa City, president. Standing, R. M. Chapman, M.D., Cedar Rapids, vice president; V. L. Schlaser, M.D., Des Moines, secretary; T. A. Burcham, M.D., Des Moines, treasurer; A. J. Havlik, M.D., Tama, trustee, and J. F. Paulson, M.D., Mason City, trustee. Upper right, James Stewart, right, receives recognition for work of Health Planning Council of Iowa. Upper middle left, L. D. Caraway, M.D., left, Amana, House speaker, confers with vice speaker, R. D. Whinery, M.D., Iowa City. Upper middle right, Scanlon Foundation loan recipients flank L. H. Jacques, M.D., Iowa City. From left, Jeffry Life, David Thomas, Dr. Jacques, Nelson Chesney, Bill Marcus, and Thomas Munyon. Lower middle left, Judicial Council members include, from left, clockwise, Hormoz Rassekh, M.D., Council Bluffs, J. F. Collins, M.D., Davenport, C. H. Denser, Jr., M.D., Des Moines, J. M. Rhodes, M.D., Pocahontas, E. E. Gamet, M.D., Lamoni, K. E. Garber, M.D., Corydon, J. E. Tyrrell, M.D., Manchester, and A. M. Dolan, M.D., Waterloo. Lower middle right, new IMS President Flocks, left, accepts gavel from retiring President Lister. Lower left, H. J. Smith, M.D., Des Moines, AMA delegate, chats with R. T. Holden, M.D., Washington, D. C., AMA trustee. Lower right, Reference Committee on Legislation and Miscellaneous Business, left, C. P. Hawkins, M.D., Clarion; T. E. Kiernan, M.D., Newton; G. R. Clark, M.D., Waterloo; IMS staffer Rick Phillips; J. E. McGill, M.D., Carroll, and S. A. Smith, M.D., Oskaloosa. Open hearings were held by all reference committees.



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ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

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TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
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T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %



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The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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Doctor's Business

by LARRY E. LEAVERTON

PUBLIC RELATIONS PROBLEMS? ASK YOUR PATIENTS

Much has been said and written about the public relations of the medical profession. Reports are frequently critical. One widely read survey concluded most patients felt well treated by their own physicians but regarded the public relations of all physicians as not entirely satisfactory.

The attitude of some physicians and their office staff might be—why bother—we have more patients than we can handle. We hope these offices are in the minority. A much more satisfying practice results from good public relations, and improves the entire medical image.

How do your patients feel about the public relations of your office? One way to find out is to ask them. One of our field consultants developed a questionnaire which was mailed with a stamped envelope to a sampling of patients. Through a questionnaire the patient has an opportunity, anonymously if he wishes, to express himself with satisfactory or dissatisfactory comments, or constructive criticism. The wording of the questionnaire will depend on the information desired and your own circumstances.

Following are some suggestions:

When you telephoned our office did the receptionist answer your call promptly and courteously? .....

When you called for an appointment how much time elapsed between the call and the actual appointment? .....

When you came to our office did you find a place to park promptly? .....

When you arrived for your appointment, how long did you wait before being seen? .....

Do you find our medical assistants courteous? ..... friendly ..... efficient? .....

Do you find our reception room comfortable? ..... If not why? .....

Do you feel that our "after hours" service (answering service, coverage, emergency room) is adequate? ..... If not, explain .....

Have we explained the answers to your questions, problems and conditions in understandable terms? ..... If not, explain .....

How do you feel about our fees in relation to other goods and services? .....

Do you have any complaints or suggestions about our billing systems? ..... Our insurance procedures? .....

We will welcome any other comments or suggestions to help us improve our service to you and your family. Use reverse side of page if needed. .....

.....

The questionnaire should be simple and brief. Ask specific questions. Indicate that it need not be signed. This will bring more frank and useful information. The form should be well designed and professionally duplicated. If you feel some replies may not come to your attention, the return envelope could be addressed to an outside party, a P.O. box, or your home.

In the example cited, the results were enlightening. A fair number of respondents reported the receptionist was frequently brusk and unfriendly. Others mentioned what they felt were unnecessarily long waits beyond their appointed time. One respondent suggested a good solution to a traffic problem in the office parking lot.

Like all surveys and studies, the efforts are wasted if nothing is done with the results. Some of the criticisms may be beyond control —for example an overloaded practice operating at utmost efficiency desperately searching for an associate, will be well aware that patients are waiting beyond their appointed time.

Public relations is the art or technique of promoting goodwill—the action of an individual in promoting goodwill between himself and the public. If you are genuinely interested in improving your public relations a questionnaire may be the answer.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

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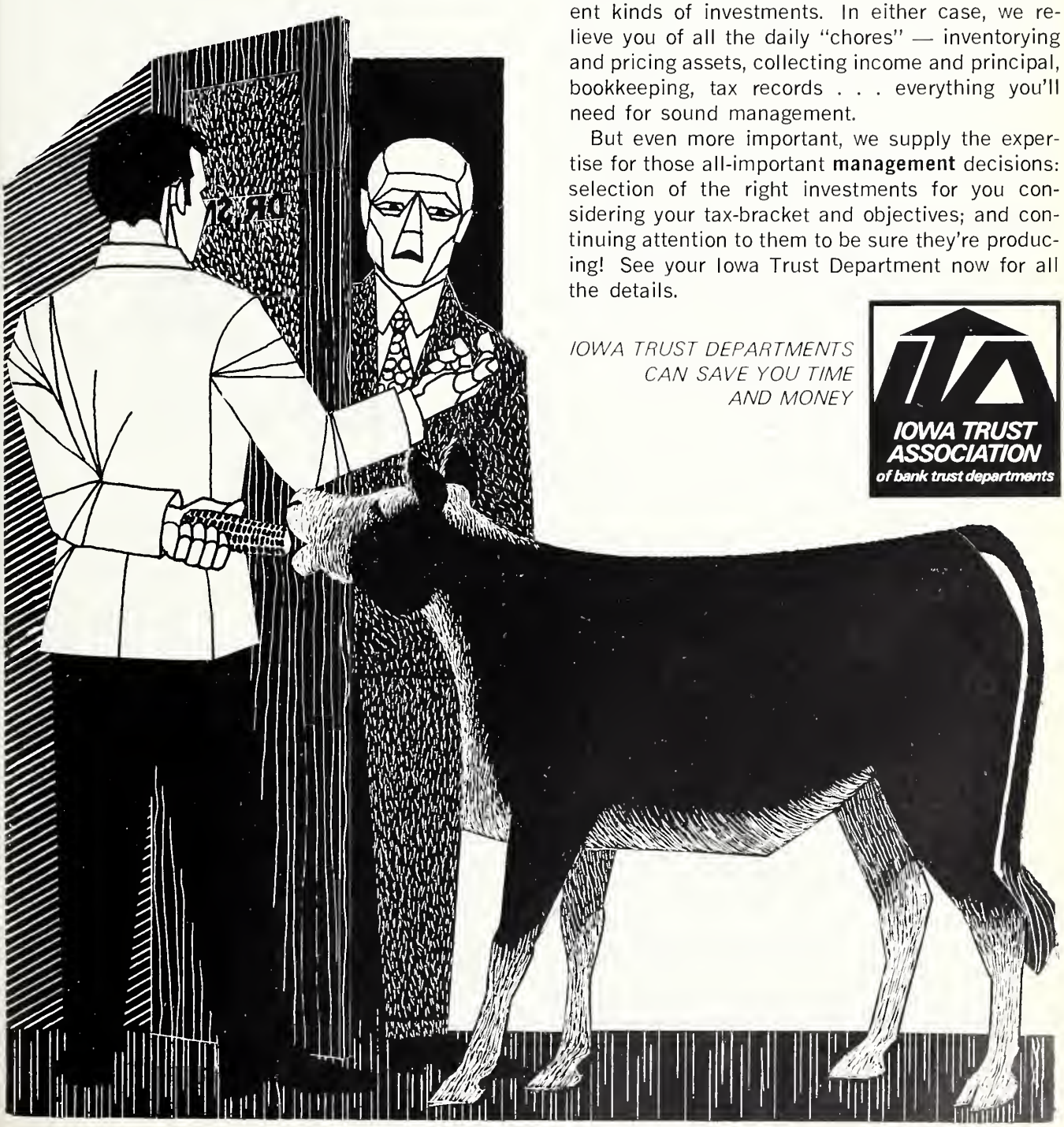
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SCIENTIFIC ARTICLES

A Small Medical Staff Renews Its Education Program

DONALD J. OTTILIE, M.D.
Oelwein

THIS PAPER is not offered as a total answer to the immediate or future continuing education needs within your medical community. It is intended rather to give you a chronological picture of how a medical staff of eight in a small rural Iowa community, with no prior organized educational activity, has structured a viable and profitable educational program. We recognize we are *not home* yet, but with the programs now in progress, and with the continuing search for more depth and productivity, we anticipate better medical care for our community.

Six members of our staff have been active in the Academy of Family Practice since 1954 and have been involved in various approved post-graduate training programs.

Our medical staff consists of eight individualists. Seven years ago we were far from being a cooperative, functioning staff. Differences existed with the administrator. With these two big problems, the inevitable happened, we lost our accreditation. We floated five years with no real staff participation except for short monthly meetings and a few monthly medical and tissue committee meetings. These superficial meetings provided only cursory evaluation of material. There was no active educational endeavor whatsoever.

Hospital survival finally became a crucial matter. Recognizing accreditation as tantamount to survival, the staff voted in 1971 to commit itself totally to achieving accreditation and we challenged the ownership to work with us.

Two months later we were on our way. A new capable administrator was employed. And a stubborn, undisciplined, maverick-medical staff, unaccustomed to rules and regulations, and unfamiliar with committee work and its virtues, was moving into gear.

Pressure, just short of physical force, was necessary to re-educate and re-tool the staff to meet medical-chart requirements of the Joint Commission. We now have no gross chart problems after rectifying some long standing abuses. This was finally accomplished through executive committee action to withhold admitting privileges, or by threatening management board intervention. This management board concept, with local consumer representation and participation by two medical staff members, was urged by the staff to the absentee ownership. This was done in accordance with the Joint Commission suggestion that members of the community be involved in meeting medical needs. The hospital owners finally agreed to develop a board with this representation and it has been meeting monthly since.

Dr. Ottilie is in the private practice of family medicine in Oelwein.

With a functioning management board, a capable administrator, and a stubborn staff, we have been able to establish various new committees. In an effort to meet the accreditation standards, the medical staff has accepted discipline and conformity. With this has come a real opportunity for the physicians to become students again. A patient-care committee was appointed to foster dialogue between the nursing service, the medical staff and administrator. At the same time, we encouraged and received staff permission to initiate a self-assessment educational program. It was a core-content type of review. We had better than 50 per cent participation in this non-compulsory program. Those involved received substantial educational stimulation.

DESIRE CCU

For many years a coronary-care unit had been a desire of the medical staff. With the new administrator we began to plan and develop a small hospital coronary care unit. We encouraged two staff members to attend several coronary care educational programs and they have since briefed other staff members in basic coronary care. In this specific endeavor, we developed common medical treatment orders acceptable to all staff members. This has led to the development of common treatment regimes in other areas of medicine.

A need for full staff participation in peer review of live patients on the medical floors became quite apparent. This was considered far more appropriate than review of cold, closed charts, or dead cases by one or two staff members in the record room. As an outgrowth, we initiated the real continuing education program of our institution—Saturday Grand Rounds—noncompulsory. At first, we presented only cases of special interest, but with unanimous staff approval, we may now see any medical case on any floor. In addition to seeing patients for staff educational benefit, we do what I call live, on the spot, bedside medical audit and utilization review. In these rounds, we learn from each other, we see how our colleagues think, and in a non-threatening probing way, we assess the educational needs of our staff, as a whole and individually.

We moved with cautionary speed. We found that group or team review and participation will work well if patience is the watchword. Alienation of colleagues will be avoided. We have achieved gradual but full acceptance of the concept of educating ourselves, individually and as a staff, without any form of compulsion. Through flexible innovation we expect to maintain our present level of motivation. We hope that continuing education in Oelwein will not be a goal but a "habit, a style, and a way of life."

In a further attempt to enhance the continuing education program the staff has established Wednesday noon conferences with rotating leadership. In these meetings we make a direct assessment of staff performance—a data-based critique—with statistical input from our medical records. We plan future educational experiences or programs to correct any weaknesses or deficiencies identified at these meetings.

Effective local continuing education programs should be linked and coordinated with other medical staffs and hospitals in the area. This collaboration between area physicians and medical staffs of other hospitals in planning continuing education is very important. Such joint participation adds the strength of numbers and increases the opportunity for medicine to guide the delivery of health care in a particular area of the state. Educational programs can be expensive, with guests, faculty, consultants and lecturers, but by sharing these costs and by rotating programs around the region, the number of educational experiences can be increased. This association with and visitation between adjacent hospital staffs helps to broaden the overall effectiveness and productivity.

HEALTH PLANNING

In Iowa's comprehensive health plan the four northeast counties were designated one of the health council areas: Howard, Winneshiek, Allamakee, and Clayton. Two adjacent counties, Chickasaw and Fayette, were assigned to the Black Hawk (Waterloo) district. A dissimilarity in medical needs, facilities and educational objectives prompted Chickasaw and Fayette counties to align with the four counties to the east and north and commit their future to what is called the Minowa Health Planning Area.

The Minowa Health Planning Area comprises six counties in the extreme northeast corner of Iowa with a combined population of approximately 120,000. It is a typical rural setting with farming as the major industry. The nine towns with hospitals in the area have

populations of under 3,000, except Decorah and Oelwein, which are 7,300 and 7,700, respectively. The area is supported medically by 73 family physicians, with approximately 25 of them over 60. The nine hospitals have an average bed capacity of 47, and an average daily occupancy of 52%. Some individual members of these hospitals' medical staffs met a year or two ago and decided to develop an area continuing education program based on local needs. A full-time director of medical education was sought. George Loeser, M.S. Ed., was appointed to the position. Through his efforts as director of the Minowa Project, we have seen an intelligent, coordinated and productive program emerge. Each physician in the area received a detailed questionnaire inquiring about his individual educational needs and the needs of his medical community. An analysis was made of these questionnaires, and this analysis was used as a guide in planning educational activities.

EDUCATIONAL CRITERIA

Repeated meetings of area hospital medical representatives produced certain criteria and objectives for the whole region. Listed here are some of these ideas that came from this dialogue between the various physicians of the area.

- Cater to the individual physician's needs.
- Recognize the need to have the program based on the community hospital.
- Supplement those educational activities already established among medical staffs.
- Offer a variety of specific program topics.
- Incorporate clinical presentations of actual cases by the attending physicians in the teaching process.
- Provide for evaluation of each program.
- Involve each Minowa Area hospital staff in a regional day-long clinical symposium. The first one to focus on coronary care as provided in area C.C.U.'s.
- Bring a different faculty-consultant or team to the area on a staggered schedule twice a month, one to teach at hospitals in Howard, Winneshiek and Allamakee counties and the other to teach in Chickasaw, Fayette and Clayton counties.

Summarizing, the proposals identify four kinds of continuing medical education:

1. Staff conferences and rounds which are already well established.
2. Clinical presentations utilizing guest faculty consultants for Saturday morning programs.
3. An annual or semi-annual regional symposium focusing on a major area of concern.
4. A goal-oriented long-range academic program.

The Minowa Project is advantageously located in that three large medical centers surround it: the Mayo Clinic, the Gunderson Clinic and the University of Iowa Medical Complex. With the advent of HMO's and their possible ramifications, with the challenge from the Carnegie Commission, with the publishing of the Coggeshall and Millis report, and with the country's recognition of medical education as a continuum and a direct responsibility of the teaching centers, we have been the recipient of gracious offers from these institutions. They have offered their unlimited teaching resources to improve the quality of medical care provided by our area physicians.

In the past some of the communities and hospital staffs have used these teaching resources, but the Minowa Project has a co-ordinated program to reach the area hospitals and medical personnel. The subcommittee on medical education has met with James C. Hunt, M.D., and Jack Osmondson, M.D., of the Mayo Clinic to tailor a program to the needs of our area physicians and also fulfill the Mayo Clinic's long standing and major commitment to post-graduate education. Out of this has come a highly successful, comprehensive Mayo Clinic visiting physician lecture series, with consultation teaching experiences, using actual case presentations by local physicians. As of this time, four successful lecture consultant series have been provided by the Mayo Clinic in Decorah, Oelwein, Cresco and Waukon. Attendance has been excellent, the meetings have been educational and stimulating, and the individual staffs have been enthused with the educational progress.

DEVELOP PROGRAMS

In several conversations with Richard M. Caplan, M.D., from The University of Iowa and Edwin L. Overholt, M.D., from the Gunderson Clinic, we have developed more visiting faculty physician programs for the Minowa area. A two-day regional clinical symposium is planned with the faculty from each of the three institutions. The first symposium will focus on coronary care provided in the Minowa area coronary care units. To provide in-depth

coronary care training we are arranging a course through the University of Iowa which is available only at the major medical centers. This course will be offered to our area physicians on a weekly basis at our Area Vocational School for a total of 18 hours.

Barriers do exist in developing a continuing education program that is active, progressive and continuous. The hospital must be regarded as the focal point for bringing together the patient (who is the textbook), the physician, and the facilities for properly analyzing their interaction. There is no better laboratory for re-training and re-education than the place where we care for our patients and meet our peers. Evaluation of patient care and educational functions of the hospital are not only related, but also synonymous. The acceptance of this concept is the first step.

EFFECTIVE SCHEDULING

The most common obstacles in a good educational program are "lack of time," "too busy," and "too many meetings and committees." This can be overcome by scheduling educational programs in the hospital during the normal working hours of your medical colleagues, and by altering committee work to make a learning experience; in other words, use grand rounds for live group medical audit and utilization review by the entire staff. Eventually the staff members will accept the time given to continuing education as a part of their "normal work pattern."

Fear of "open case discussion" on the floors can be an obstacle to initiating and developing this type of hospital program, but by gradual evolution with in-depth involvement, plus a non-compulsory, but encouraging, approach to attendance, the staff will soon recognize this interchange of ideas and concepts between fellow physicians is non-threatening and actually a gratifying and rewarding experience. Fear of visiting consultant lecture programs is usually dispelled after patients are seen benefitting from this type of involvement.

For some busy physicians, who are highly motivated and energetic, there are no insurmountable barriers. They pursue voluntary education programs eagerly. Fortunate is the medical community who has this type of person to offer leadership. Motivation is the real key to any successful program—motivation of each staff member, and then group motivation. External motivation through recognition and awards from state or national professional associations is not a strong enough stimulus. Recognition of family practice as an equal in the specialty spectrum has done much to encourage and re-kindle the pride of the family practitioner. His status in the medical delivery system is enhanced and he recognizes and accepts his increasing need to excel, and to be well educated and informed.

Continuous motivation depends on enthusiastic, uninterrupted local leadership, and, when possible, affiliation with a medical center. A great advance in medical education has come with acceptance by the teaching institution of the responsibility for the life-long education of the physician. Our universities should provide not only the opportunity to learn, but they should stress the importance of life-long self education. Programs developed and accepted by the entire staff must be innovative, coordinated, flexible and challenging. Pride in group accomplishment which improve overall medical care at each hospital is important in any successful program. Area wide hospital participation in various educational programs sparks worthwhile team effort.

Universities have not had sufficient faculty to provide this support, they have lacked interest in local level community progress; there has been a lack of adequate teaching facilities at the local level, and a lack of local funding for a visiting physician program. Of great benefit to medicine as a whole can be this personal, on the scene interaction between the family physician and the educator at the local level. Lack of exposure or exchange in the past has been a big cause of misdirection in medical school education. Medical educators have had limited knowledge of the practice conducted in the rural areas by the family physician. Research, sub-specialty training, and academic excellence were the main purposes in education—practicality and comprehensive human involvement were secondary. The re-direction of medical education in the last several years is encouraging and will do more than anything else to motivate the student as well as the practitioner to excellence in his chosen field of medicine.

Financial support from a hospital board and administrator is most important to a successful education program. It must be constant and liberal if it is to improve medical care. This commitment must be made initially and must be assured for years to come.

Any worthwhile and lastingly effective educational program must be evaluated regularly to determine if it has met its objectives. The evaluation should provide:

1. Participants, both teachers and students, with personal feedback about the results of their efforts.
2. Measures of the program's impact.
3. The basis for making decisions regarding program changes that might be needed in the future.

The educational program may be assessed in various ways: attendance and opinion, knowledge and skill acquisition, practice change, and by impact on patient care.

Other means of assessing progress are through the Professional Activity Study (PAS) and the Medical Audit Program (MAP), Time Related Utilization Review System, the Bi-Cycle Concept (relating continuing education directly to patient care) and Quality Assurance Program (QAP).

The public, many ambitious politicians, as well as state and national government health care officials are pressuring to change and control health delivery and medical education. We need to move now before we are pushed by these non-professionals into questionable, unreasonable post-graduate programs. In other words, we must take individual and collective initiative while reasonable, appealing and productive options are still available to us.

In any initial approach to continuing education, three simple steps must be followed: identify your individual and medical staff problems in patient care; assess your strengths and weaknesses as individuals and a staff; and then set up your educational objectives and programs. All three objectives must have entire staff input and participation.

TERMINATION OF PREGNANCY

(Continued from page 248)

and can be safely discharged by the physician.

8. Postoperative instructions and arrangements for followup, including family planning advice.

9. Reporting of legal induced abortions is essential. The State Department of Health should assume the responsibility for collection of the necessary data and preservation of the confidentiality of such information.

It is recognized that termination of pregnancy may be performed at a patient's request or upon a physician's recommendation. *No physician or supporting personnel, or hospital or other facility should be required to perform or assist in the termination of pregnancy procedures;* nor should any patient be forced to accept termination of pregnancy.

The usual informed consent, including operative permit, should be obtained. A patient who is married or 19 years of age (18 years of age effective July 1, 1973) may give her own consent. For other patients consent must be given by parent or legal guardian.

It is important that the provision of abortion services not interfere with the care of other obstetric-gynecologic patients or with residency training programs in obstetrics and gynecology. Consideration should be given by hospitals to providing facilities where termination of pregnancy can be performed with minimal disruption of other hospital function.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

June 13-14	Seminar an Treatment af Human Sexual Inadequacy (Canference Center—Carausel Matel —Iawa City)
July 11	Cammunity Clinical Canference Dealing With Emergencies (Braadlawns Palk Caunty Haspital —Des Maines)
July 25-26	1973 Refresher Caurse far Family Physician "Mini-Versian"
July 27	Warkshap an Preceptarships and Teaching Skills far Practicing Physicians

Unless atherwise specified all courses and canferences are held at The U. of I. College of Medicine, Iawa City.

Ammonia Eye Injuries

N. I. JARUDI, M.D., and
BRUCE GOLDEN, M.D.
Iowa City

AMMONIA is commonly used as a cleaning agent in nearly every household as well as in many pharmaceuticals and pesticides. The high nitrogen content of anhydrous ammonia makes it a desirable, inexpensive fertilizer which has been used increasingly in agriculture over the last 20 years. A very significant property of ammonia is its extreme solubility in water. One volume of water can dissolve 1300 volumes of the gas.[1] Because of this property, ammonia rapidly dissolves into the water of living tissues, especially the surfaces of contact, such as the mucous membranes of the upper respiratory tract, skin, and eyes causing severe caustic burns. The severity of the burn depends on the concentration of the gas and the duration of the exposure.

Ammonia respiratory injuries may be lethal, and the skin burns may be disfiguring; however, the eye injuries constitute the most common cause of permanent disability. Acid burns usually involve the outer cell layers of the corneal epithelium. Alkalis, on the other hand, tend to form soaps as they react with the fatty epithelial layer, after which they rapidly traverse the stroma and result in disruption of the endothelium. Because of the very high solubility of ammonia, exceptionally rapid entrance into the anterior chamber is encountered.

With severe exposure, ammonia reaches the iris and starts cataractous changes in the lens. The trabecular meshwork becomes edematous and sometimes plugged with iris pigment and inflammatory cells resulting in a rise of the intraocular pressure, which may be detected as early as a few hours after the exposure.[2] Marked edema of the cornea (Figure 1) appears a few minutes after injury. Damage to the limbal and episcleral vessels may be seen in the form of hemorrhages and marked pallor, secondary to thrombosis of these vessels. Within weeks, infiltration of the cornea by inflammatory cells results in fibrosis and neovascularization. The metabolic processes of the cornea are thus markedly disturbed which makes corneal transplantation a less successful procedure. Ulceration of the conjunctival surfaces may cause adhesion of the lids to the globe. Severe iridocyclitis results in adhesions of the iris to the lens. Pathological processes resulting from an ammonia burn of the eye



Figure 1. Marked edema of the cornea with folds in Descemet's membrane a few minutes after an ammonia burn.

Dr. Golden was an assistant professor in the Ocular Inflammatory Disease Service, Department of Ophthalmology, The University of Iowa College of Medicine. He is now Professor of Experimental Ophthalmology in the Department of Ophthalmology at the University of the Witwatersrand, Johannesburg, South Africa. Dr. Jarudi was a clinical fellow at The U. of I. when this article was prepared and is now in practice in Beirut, Lebanon.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JUNE, 1973.

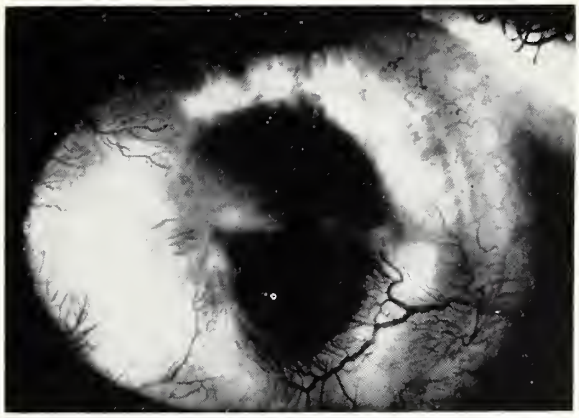


Figure 2. Scarring resulting from an ammonia burn.

may regress to an endpoint in which the cornea, iris, and lens are indiscriminantly fused into a mass of vascular granulation tissue (Figure 2). Marked reduction of vision is secondary to opacity of the cornea, irregular astigmatism, cataract, glaucoma, or atrophy of the whole globe as seen in Figure 3.

TREATMENT

Immediate and very thorough irrigation of the injured eye is the most important step in the treatment of ammonia burns.

It is always wise to assume that the irrigation instituted from the time of the injury until the patient reaches your medical facility has been inadequate. Thus, 0.5% proparacaine drops should be instilled to allow proper irrigation of the eye. No time should be wasted looking for an antidote chemical for irrigation since water is very appropriate. Washing should continue for at least 60 minutes as the involved tissues may still be releasing ammonia for more than 15 minutes after proper washing begins.[2] At The University of Iowa Hospitals, it is the practice to irrigate the eye with 5-10 liters of normal saline or lactated Ringer's solution through a disposable sterile device (Mediflow) (Figure 4). Figure 5 shows the saline flowing through the Mediflow lens and irrigating the ammonia which is continuously released from the tissues.

After thorough irrigation a cycloplegic such as 0.2% scopolamine or 1% atropine should be used to combat the problems of iritis. A combination of such a cycloplegic with a mydriatic like 10% neosynephrine insures mobilization of the iris.

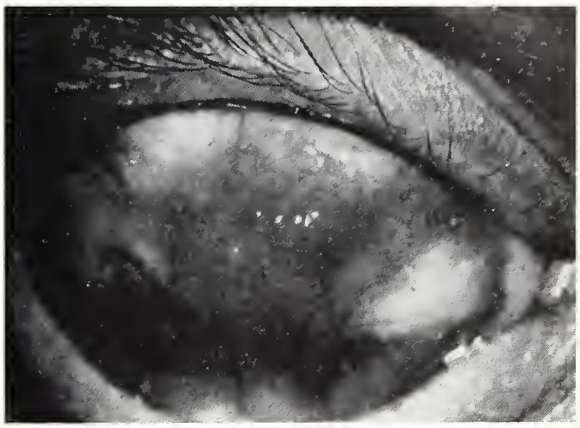


Figure 3. Atrophy of the globe as a result of a severe alkali burn.

The cornea releases a self-destructive enzyme (collagenase) whenever it is damaged. This may perpetuate corneal ulcers, particularly those caused by ammonia burns. Unless severely injured by ammonia, the eye may look relatively quiet for one to three weeks, after which it starts to break down. Treatment with agents that counteract this enzyme appears to prevent this delayed destruction. The class of agents employed for this purpose is termed "anticollagenases" such as 10% mu-



Figure 4. Mediflow contact lens employed in irrigation of the eyes.



Figure 5. Irrigation through the Mediflow lens using 5-10 liters of normal saline or lactated Ringer's solution.

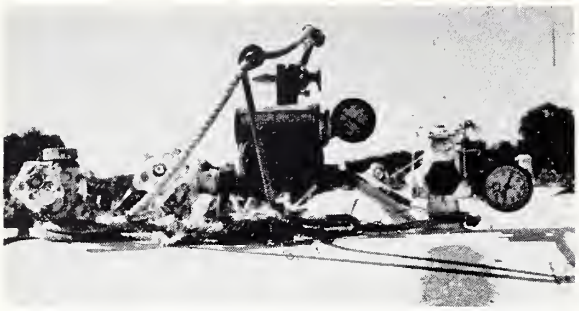


Figure 6. Multiplicity of hoses, valves and fittings where the leak of anhydrous ammonia may occur.

comyst®, 0.25 molar l-cysteine, and 0.2 molar calcium EDTA, all of which have proved to be useful, although not yet approved by the Food and Drug Administration for this purpose. Steroids inhibit the regeneration of the corneal collagen and should not be used prophylactically unless signs of marked inflammation are present. One per cent prednisolone may be used, if necessary, to combat this inflammation and may be applied every one to two hours around the clock, but never without concomitant application of an anticollagenase.

Brown *et al*[3, 4] found that in rabbits, the eyes receiving steroids after an alkali burn showed less neovascularization, but they had a high incidence of corneal perforation. This is probably due to the collagenolytic effect of the steroids.

The intraocular pressure is best determined in an involved eye by the MacKay-Marg tonometer, and when elevated, 500 mg sequels of Diamox should be given every 12 hours.

Occasionally, marked progressive blanching of the conjunctival blood vessels may be noted after an alkali burn. This usually indicates thrombosis of the limbal vessels which may result in necrosis and perforation of the cornea secondary to decreased corneal nutrition. The use of 450-1000 units of heparin (in 0.5 cc of normal saline) injected daily subconjunctivally for six days may help prevent this complication, although it remains an experimental procedure.

A bacterial culture should be taken routinely from the involved eye and 10% sulfacetamide may be applied prophylactically. It has been our clinical impression that eyes involved with an alkali burn may develop a dry eye syndrome which, unless recognized and treated by frequent applications of artificial tears, may lead to persistent corneal damage and further insult to an already diseased cornea.

ACCIDENT PREVENTION

The prevention of accidents cannot be overstressed. Every person involved in the use of ammonia should be fully aware of the hazards involved. It should be stressed that commercial cleaners should be used without homemade additives, as cocktails of various household cleaners may result in the release of toxic gases such as ammonia or chlorine.[5] In agriculture there is no absolute guarantee that chemicals will not escape from the container or fittings during movement from production plant to the field. A most common accident situation involves transfer of the pressurized liquid from tank to tank. The ammonia fertilizer is usually transferred by farmers from one container to another at least three times between the factory and farm, and each procedure involves hoses, valves and fittings, each of which may occasionally be defective or extensively worn (Figure 6). The typical farm injury involves a man hit by the vapor stream who usually scrambles out of the vapor path to close a valve and shut off the flow of the ammonia.

FIRST AID

Proper first aid procedures stressing immediate copious irrigation of the eye should be explained to local police or firemen who may provide initial help to the exposed patient. The physician might also take the opportunity to talk first aid to the farmers or ammonia handlers, particularly emphasizing the immediate irrigation for at least 30 minutes at the moment of injury. Important points to remember in the immediate treatment are the following.

1. *Proper generous irrigation.*
2. *No ointment should be applied to the eye.*
3. *Contact lenses should be removed to ensure proper irrigation.*
4. *The patient should be referred to an ophthalmologist as soon as possible.*

Every person working with ammonia should be aware of the hazards involved and should always:

1. *Use tight fitting goggles and rubber gloves at all times.*

2. Have a protective garment readily available in case of leak.

3. Stay out of line of valves or hose couplings.

4. Stand upwind during a transfer operation.

5. Have ample water supply available for immediate irrigation in case of exposure.

SUMMARY

In summary, the following points should be remembered in the treatment of ammonia burns:

1. Inspect the fornices by everting both lids.
2. Copious irrigation using the Mediflow contact lens and at least 5-10 liters of normal saline or Ringer's solution per eye.
3. Adequate sedation of the patient.
4. An anticollagenase applied to the involved eye at a frequency ranging from hourly to once every six hours for at least 30 days in moderate injuries, and three or more months with severe cases.
5. Dilate the pupil with 0.2% scopolamine eye drops.
6. Check and control the intraocular pressure.
7. Use prophylactic 10% sulfacetamide.
8. If severe inflammation is present, use 1% prednisolone in doses ranging from hourly to every six hours, but not without the concomitant use of an anticollagenase.
9. Be aware of decreased basal lacrimal secretion and treat with artificial tears.
10. Educational materials may be obtained from the Iowa Society for the Prevention of Blindness, Des Moines, Iowa 50309.

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IOWA MEDICAL MISCELLANY

(Continued from page 245)

LIFE MEMBERS . . . Life Membership in the Iowa Medical Society was bestowed upon 10 physicians April 30. Honored were S. W. Barnett, M.D., Cedar Falls; W. O. Preece, M.D., Waterloo; J. H. Wise, M.D., Cherokee; H. E. Stroy, M.D., Osceola; F. J. Piekenbrock, M.D., Dubuque; J. O. Eiel, M.D., Osage; Louis Kornder, M.D., Davenport; F. B. Leffert, M.D., Centerville; Dennis H. Kelly, Sr., M.D., Des Moines, and C. A. Sones, M.D., Des Moines.

DEDICATION . . . Formal dedication of the $15.8 million Basic Science Building at The University of Iowa occurred April 26 in Iowa City. New building has nearly seven acres of floor space on six levels and houses Departments of Anatomy, Biochemistry, Microbiology, Pharmacology, Physiology, Biophysics and the Animal Care Unit.

SAFE TRANSPORTATION . . . IMS Safe Transportation Committee will host a June 14 conference for officials of the Department of Public Safety and the Iowa Highway Patrol at Society Headquarters.

MECO PROJECT . . . 79 U. of I. medical students will spend 10 weeks this summer in 50 Iowa hospitals under the MECO project. Program has grown significantly since 1970 beginning when 17 students participated. Intended for about-to-be sophomores, the program is coordinated by the U. of I. chapter of SAMA with assistance from the College of Medicine, the Iowa Medical Society and the Iowa Hospital Association.

TO AMA POST . . . Former Iowa physician Frank Coleman, M.D., now of Tampa, Florida, has been named chairman of the AMA Council on Health Manpower.

RESIGNS . . . James N. Gillman resigned in April as Iowa Commissioner of Social Services to become a vice-president with Blue Cross of Iowa. He served as Commissioner since 1969.

PHYSICIAN'S ASSISTANT . . . The new U. of I. PA training program has passed the first step in gaining accreditation from the AMA. Preliminary approval has been granted by the AMA Council on Medical Education's Joint Review Committee on Education Programs for the Assistant to the Primary Care Physician.

(Please turn to page 271)

Editorials

M. E. ALBERTS, M.D., Scientific Editor

MOVE ONE SPACE FORWARD (BACKWARD?)

Numerous systems have been introduced to provide patient care without direct physician contact. The greatest impetus has been placed on the use of physician's assistants or nurse practitioners. The problem, however, is how far these assistants may go in direct patient care. Duties may be delegated along rather specific lines by the physician when he works side-by-side with his nurse, but what of the assistant who is given responsibility over and beyond being a helping hand? This question is raised often because of possible medical-legal implications, as well as a pure delineation between being an assistant and the actual act of practicing medicine.

There has been a recent report* on the use of a clinical algorithm system for patient care. It has also been used to audit the performance and education of medical assistants. A clinical algorithm is a step-by-step clearly delineated process for solving a medical problem. In a sequential charting of various signs and symptoms the assistant is directed in the care of a specific category of illness, e.g., upper respiratory infection. Each step provides either a definite instruction on what the assistant is to do next, or sets forth an alternate pathway which calls for another step before coming to a conclusion regarding disposition of the individual case. For example, the clinical algorithm for upper respiratory illness first indicates doing an examination of the throat. If the examination reveals an abnormality the flow-chart indicates a specific course; if the examination reveals no abnormality another pathway is indicated. Then, assuming the throat is abnormal on examination, the next step asks if the epiglottis is swollen. If it is, the next instruction is to send the patient to the physician. If the epiglottis is not swollen the question is asked if only one tonsil is swollen, of course seeking the possibility of a peritonsillar abscess. Each step provides a "Yes" or "No" alternative.

Algorithms were available in this study for a number of different categories—ear problems, cough, chest pain, urinary symptoms and others. The most commonly used algorithms were for upper respiratory illnesses, ear problems and cough. Though the clinical algorithm provides instructions for gathering and interpreting data, thoroughness and reliability of the physician's assistant will be reflected by the ability to follow instructions. However, the system does not measure the accuracy of observations made by the physician's assistant; this can be done only by the physician. Through programs of utilization checklists and computer analysis, it was demonstrated that a physician's assistant could have evaluated 45 per cent of patients without direct physician involvement as long as the algorithm logic was followed correctly.

All this is great as long as the primary observer of the patient recognizes what he sees. I have observed instances where an abnormal tympanic membrane was not recognized by a physician; where a swollen epiglottis was missed. How much responsibility can be placed in the hands of a nurse or other trained assistant when the assumption of full liability

* Sox, Harold C., Sox, Carol A., and Tompkins, Richard K.: The training of physician's assistants. New Eng. J. Med., 288:818-824, April 19, 1973.

is carried by the physician? Much clarification of the technicalities is absolutely necessary. What of insurance payments for the services rendered? Can the physician be expected to bear the entire legal responsibility for the diagnosis and treatment? Each position forward could become a step backward in good medical care. True, more people can be seen (and treated) in less time, and probably the odds will be in favor of correct decisions. But, what of that one big mistake? Who will take the blame?—M.E.A.

WISDOM

The April 1973 issue of FEDERATION BULLETIN is dedicated to the memory of Iowa's revered Dr. Walter L. Bierring. The 18th Annual Bierring Lecture was presented at the February meeting of the Federation of State Medical Boards by Charles Hoffman, M.D.* Dr. Hoffman is about to conclude his term as the 127th president of the AMA. He spoke on "Half-truths versus wisdom" in his tribute to the great Iowan who served as AMA president in 1935. Many of Dr. Hoffman's statements are worthy of our concern.

Dr. Hoffman directs attention to the length of time a physician must spend in attaining his degree and license to practice medicine. He points out that many basic sciences are being abolished from the pre-medical curriculum, and the humanities are not considered important. The cultures of medicine are being lost, and it is these cultural aspects that make a physician mature, and sharpen him to assume the supreme responsibility involved in matters of life and death. It is interesting at a time when other countries are extending the physician preparation time, schools in the United States are shortening the time required for a medical education. The President of the Swedish Medical Association told Dr. Hoffman recently that his "greatest fear is that government, in order to centralize medicine, will shorten the length of medical education and there lies the folly."

Another concern expressed by Dr. Hoffman involves use of nurse practitioners. He told of a visit to a clinic in New Mexico where patients were seen primarily by nurse practitioners. Male nurses were doing complete examinations (including pelvics on women). The physicians saw only 5 per cent of the patients. Yet, in Russia where the feldscher system of medicine has been in existence for 250 years, this second level of medical care is being phased out. Dr. Hoffman expresses fear the physician's assistant program will boomerang and "come right back and slap us in the face."

The discontinuation of the traditional internship is another point of concern. This goes hand-in-hand with the matter of education—an apprenticeship in a manner of speaking. No longer is this 12 months of slavery without compensation, excepting the educational benefits and a few dollars. Today's intern is in the five-figure class for the most part, and in many places without the long, tedious, unending hours of toil as in the past. A real reason must be shown for change. Specialization is not the answer. The dentists are not shortening their education requirements. Labor unions will never cut down their requirements for bricklayers and plumbers. It would appear that the medical profession has listened to a group of social planners and has been overcome by something without thinking it out. Therein lies the meaning of wisdom: 1) the ability to distinguish half-truths, 2) the desire to define a problem clearly before proposing a solution, and 3) the ability to judge a proposed solution in light of all consequences, both good and bad.

Some of the proposals being advanced today for medical education and delivery of medical care fail to pass the test of wisdom. Instead they smack of rashness born of impatience. Americans are impatient people and problems breed discontent. Instant cures are demanded, and what we receive too often instead are placebos, according to Dr. Hoffman. Perhaps a new look or the exercise of wisdom is indicated in the education of medical students and the utilization of medical personnel. Wisdom must be added as a catalyst to the overpowering movements advocated by the social reformers.—M.E.A.

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* Hoffman, Charles A.: Half-truths verus wisdom. Federation Bulletin, **60**:114-126, April, 1973.

U100 INSULIN

The confusion of insulin units may be overcome easily with the introduction recently of U100 insulin. Confusion in the minds of patients about U40 and U80 has been common. It seems that some look upon them as two entirely different forms of insulin when in reality they are different only in concentration of the solution, but requiring different syringes for accurate utilization by the average individual.

The metric system is to be our way of life in coming years, and it is commendable that insulin will be available in this same unit of measure. Eventually U100 insulin will be the only concentration available. Syringes of conventional metric scale will provide more accuracy. The fact that each milliliter of the new solution will contain 100 units of insulin provides easy calculation of dosage. Compared to U40 and U80 it remains that 10 units of insulin lowers the blood sugar to the same degree.

The U100 insulin will be available in rapid, intermediate and long-acting forms. The present form will be available for a reasonable period of time to afford opportunity for education of patients and physicians in the change to the new product. The American Diabetes Association expresses the hope physicians will inform themselves of this new preparation and actively assist their patients in securing the benefits of this advancement in the treatment of diabetes mellitus.—*M.E.A.*

PSRO

There is much concern in most hospitals about the impact of the PSRO provisions in Public Law 92-603 (originally known as H.R. 1). The professional standards review provision stipulates the focus initially will be upon institutional care, but eventually will include review of the individual health-care providers. One fact some physicians seem to overlook is PSRO is now a Federal Law. There is no way, at present, to avoid or circumvent its provisions.

There are provisions to make the situation more acceptable, and the medical staff at every hospital would be well advised to develop and implement as soon as possible an acceptable review committee. The demonstration that an existing hospital review committee is providing effective quality and utilization controls is enough for the PSRO's to accept their findings. In the event a hospital review committee does not exist or its actions are not acceptable, reviewing duties will be assigned by PSRO. All final decisions as to professional conduct or acts of MD's or DO's must be made by doctors of medicine or osteopathy, based on regional "norms" of treatment, diagnosis, care and utilization. The cost of the medical service does not come under the scrutiny of this review.

PSRO is fact. PSRO is law. The challenge to the medical profession to implement the provisions should be met with a renewed enthusiasm to provide excellent medical care as well as effective cooperation with all involved in the provision of health care. Careful and considerate interaction must prevail among physicians, consumers, institutions, insurance carriers and government. Face the facts; it must *be* done, or it *will be* done. Study the meaning of that last sentence, doctor. The meaning is clear. We must provide grass-roots review committees in our hospitals by our own initiative, or. . .

Will there be benefits from PSRO's? Certainly there will be problems, but as stated in Section 249F, the purpose is "to promote the effective, efficient, and economical delivery of health care services of proper quality. . . ." It will be determined whether services were medically necessary, within appropriate professional standards, and whether certain inpatient services could have been more economically rendered on an outpatient basis or in a different type of facility. Inasmuch as

many facets of our complex society are involved in health care there are more interests in the total picture. Some dissenters would call the entire scheme "police action." Look about you. There are some areas that do need action. Any of you who have been on the utilization committee of a hospital medical staff know the problems.

What of the physicians who violate the provisions of PSRO? There are specific functions, responsibilities and methods of appeal; but there are penalties also. Violators may be banned from participation in government-funded programs. Should there be a desire to avoid being banned and to continue with the program the violator may be reinstated by payment of a fine of $5,000, or the cost of the improper service rendered, whichever is less.

Review the facets of the law. Provide only medically needed services. Meet professionally recognized standards of care. Provide inpatient care only when necessary, and only at the proper level of inpatient institution. Help yourself by helping the PSRO. It's a part of your life now; as sure as death and taxes. In fact, your taxes are funding the program, and you are "dead" if you do not go along with it.—*M.E.A.*

LETTERS TO THE EDITOR

Dear Editor:

In the March 73 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY, you asked why the Iowa statistics for drinking drivers in fatal accidents are so low. Here is one possible answer:

Enclosed you will please find two forms (omitted here) to be completed by medical examiners. Please note the Report of Investigation by Medical Examiner is to be sent to the Department of Public Safety, while the Summary of Autopsy is sent to the Department of Health. Therefore, when a driver is fatally injured, the results of the blood alcohol may not reach the Department of Public Safety.

As a member of the IMS Committee on Safe Transportation, I have brought this "discrepancy" to the attention of the Department of Public Safety but I do not know of their liaison with the Health Department.—C. W. MAPLETHORPE, JR., M.D., Toledo, Iowa.

Editor's Note—Communication failure raises its ugly head again. The reports noted in Dr. Maplethorpe's letter are pertinent to the evaluation of all deaths investigated by the medical examiner. These reports ask whether an autopsy was performed, but stop at that point. The suggested distribution of the autopsy report includes the County and State Health Departments with the parenthetic notation "form will be distributed by the State Department of Health to the appropriate State Agency." Cannot the Commissioner of Health direct that copies of all such reports of autopsy be sent to the Department of Public Safety?—M.E.A.

Dear Editor:

I am editing a book on renowned and notable physicians and their faith. I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler and Sir William Fleming, however the notable physicians could still be alive.

Anyone interested in this project or who would suggest renowned physicians to write about may contact me at 4-C Doctor's Park, Asheville, North Carolina 28801.—CLAUDE A. FRAZIER, M.D., Asheville, North Carolina.

State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

THE MEASLES PICTURE IN IOWA

During the past two school terms, several Iowa counties haxe experienced sizeable outbreaks of rubeola, primarily among elementary age children. The classic epidemic pattern for rubeola has prevailed in the majority of these outbreaks. A single case occurs in an elementary school child who is frequently not seen by a physician because, "mother knows measles." Following an incubation period of 10 to 14 days, one or two more cases occur in the same family or school. After three or four generations of such small numbers of cases, a spectacular increase in the number of cases occurs and subsequently involves the entire *unimmunized* or *inadequately immunized* portion of the school population. This susceptible group is often 30% of the total student enrollment.

Several other outbreak observations have been disturbing. First of all, the disease is not contained within the boundaries of a single classroom, a single school or even a single community. The experience has been that, concurrent with the fourth or fifth generation of closely-related cases, measles begin to appear in other schools and other nearby communities. Also, it has been disturbing to note some of the children who contract rubeola during these outbreaks report a history of previous inoculation with live virus measles vaccine. And finally, all too frequently, the local physician or physicians have been the last persons in the community to hear about or see a case.

It has been the responsibility of the Iowa State Department of Health Immunization Program to research these outbreaks, to assist with their rapid containment and to formulate recommendations for local medical societies, local health departments, public health nurses and school nurses to use in the prevention of future rubeola epidemics. Under the direction of a competent physician and epidemiologist, the State Department of Health has formalized a "Standard Operating Procedure" and is prepared to assist with any local activity related to measles control and eventual eradication.

The Iowa State Department of Health remains convinced the ideal place for a child to receive an inoculation of any type is in the office of a family physician or pediatrician. Any support or assistance provided by State Health Department personnel to mass immunization campaigns has been offered in the absence of an alternative solution to the immediate problem. When a case of preventable contagious disease threatens or actually occurs and a reservoir of susceptibles is present, an effective method of preventing a sizeable outbreak of the disease is the rapid administration of the specific immunizing agent to all susceptibles in close contact with the case. When rubeola vaccine became available in quantity, the Iowa State Department of Health supported mass immunization campaigns (1966-1968) in an attempt to alter the traditional cycles of epidemic measles. When quantities of rubella vaccine became available in 1970, the Iowa State Department of Health conducted mass immunization campaigns in an attempt to alter the traditional 6 to 8 year cycles of epidemic rubella. When Iowa began to experience a resurgence of rubeola in elementary school children (1971-1973), the Iowa State Department of Health conducted or supported localized mass immunization campaigns in an attempt to stop the spread of measles.

Accordingly, the first step in the current "Standard Operating Procedure" for the control of measles and other contagious prevent-

able diseases is the *rapid* inoculation of all susceptibles in the immediate vicinity of a known case. Translated into practice, the Iowa State Department of Health recommends that:

When a physician-diagnosed case of measles occurs in an elementary school child, a measles immunization clinic should be held as rapidly as possible and preferably within 24 hours of the case report for all children in that school and for their brothers and sisters. This is called a "Rapid Response Clinic."

There are personnel of the State Health Department available to organize or to conduct these emergency rubeola clinics. A sample form has been designed which notifies parents of the clinic and specifies the children who should participate. All that is required of the local private medical community is that a physician be on site for the one to two hour clinic in case of medical emergency. The vaccine injections are frequently administered by registered nurses or technicians qualified in the use of immunization injector equipment. The rationale for this "Rapid Response Clinic" is basic. Our studies suggest, in any given elementary school in Iowa except those with *intensified* programs conducted during the past two years, 30% of the total enrollment is susceptible to measles and will contract and spread the disease unless some interruption of

Morbidity Report for April, 1973

Diseases	April 1973	1973 to Date	1972 to Date	Most April Cases Reported From These Counties
Amebiasis	1	4		Dallas
Brucellosis	1	2	11	Webster
Chickenpox	1416	9020	5112	Scattered
Conjunctivitis	258	656	425	Scattered
Eaton's agent infection	3	10		Shelby, Story, Winneshiek
Encephalitis, viral	2	5	4	Johnson, Marion
Encephalitis, type unspecified	2	9	1	Iowa, Linn
Erythema infectiosum	349	1120		Scattered
Erysipelas	2	2		Linn, Madison
Gastrointestinal viral infection	387	4801	3755	Scattered
Guillian-Barre syndrome	2	2		Jackson, Scott
Hepatitis, infectious	15	103	101	Linn, Marion, Woodbury
Hepatitis, serum	3	19	19	Polk
Hepatitis, type unspec.	1	6		Madison
Herpes simplex	13	17		Johnson, Jones, Pottawattamie
Herpes zoster	4	6		Adair, Jasper, Johnson, Lee
Histoplasmosis	2	3	12	Mahaska, Scott
Hookworm	1	1		Emmet
Impetigo	24	173	203	Scattered
Infectious mononucleosis	89	359	398	Scattered
Influenza-like illness	930	10795		Scattered
Influenza—lab confirmed	5	96		Cherokee, Fayette, Greene, Linn
Meningococcal meningitis	2	7		Dallas, Marion
Meningitis, bacterial	1	1	1	Warren
Meningitis, due to staph	1	1		Lee
Meningitis, type unspecified	3	11	7	Des Moines, Dubuque
Mumps	403	2385	4652	Scattered
Pediculosis	27	80		Scattered
Pinworms	1	1		Scott
Pneumonia	98	503	343	Scattered
Rabies in animals	26	86	93	Scattered
Rheumatic fever	2	11	17	Black Hawk, Pottawattamie
Ringworm, body	11	61	42	Scattered
Rubella	33	151	299	Scattered
Rubeola	41	184	368	Scattered
Scabies	1	6		Johnson
Streptococcal infection	802	3516	3363	Scattered
Tuberculosis, active	7	39	41	Clinton, Guthrie, Johnson
Tuberculosis, inactive	2	9		Jones, Pottawattamie
Roseola	1	1	5	Dubuque
Salmonellosis	8	31	33	Johnson, Dubuque, Marshall
Shigellosis	13	97	83	Dubuque, Linn, Polk, Page
Venereal disease				
gonorrhea	414	1884	2112	Scattered
lympogranuloma venerum	1	1	3	Polk
syphilis	33	121	165	Scattered

the virus spread is accomplished.

Four counties requested state assistance in the control of epidemic measles between September 1971 and June 1972. During the current school year, an additional 11 counties requested such assistance. During the two school terms, 12 other counties have elected to conduct special measles immunization clinics although no disease was present. It can be postulated the remaining 72 Iowa counties may expect to see a resurgence of rubeola during coming school years unless some action is taken to eliminate the "reservoir" of measles susceptibles in elementary schools.

The second recommendation of the Iowa State Department of Health in the control of measles and other contagious preventable diseases applies both to those locations which have conducted a "Rapid Response Clinic" when disease has occurred and to those counties which do not presently have physician-diagnosed rubeola:

As soon as possible, every Iowa elementary school should: (A) Make a concerted effort to identify the measles susceptibles among its enrollment, and (B) Make arrangements for the immunization of all identified as susceptible.

There are three known groups of elementary children in danger of contracting measles: (1) Those who have never had the disease or the live virus vaccine; (2) Those who may have received the live virus vaccine prior to reaching one year of age, and (3) Those who may have received a dose of gamma globulin administered simultaneously with a dose of live virus vaccine. There is some evidence that persistent maternal antibody in children less than one year of age or a simultaneous dose of gamma globulin may have interfered with the child's ability to develop antibody following measles vaccine administration. The protection afforded by such vaccine administration may be of shorter duration than that produced by a single dose of live virus measles vaccine given alone after the child was a full 12 months of age. Children to whom measles vaccine was administered with simultaneous gamma globulin or when they were less than a year old ideally should be considered susceptible. Trained personnel of the State Health Department are available for consultation related to the identification of susceptibles.

Some mass clinics may be indicated to accomplish the immunization of a larger number of identified susceptibles, with the actual administration of vaccine being done by local physicians or nurses. The state representatives will help local medical officials become proficient in the use of vaccine injector equipment for mass clinics. Where vaccine injection equipment is not used the necessary single dose vials of vaccine can be supplied.

Identification and immunization of all currently susceptible children will not prevent a recurrence of disease at a later point in time. A third and vital recommendation in the control of preventable disease is:

There must be formulated and initiated in every Iowa county an ongoing immunization maintenance program designed to insure adequate immunization of all infants prior to the second birthday and certainly no later than entry into school.

This concept of proposing infant immunization maintenance programs is certainly not new. The Iowa State Department of Health has traditionally recommended that a baby have a complete series of DPT and polio vaccine by six months of age and that measles, mumps and rubella vaccines be given on or near the first birthday. What may be significant, particularly to officers of local medical societies or county boards of health, is that the Iowa State Department of Health is now, more than ever before, capable of providing significant assistance to local medical and health personnel in order to accomplish this goal of early and adequate immunization of all infants. Immunization specialists, responsible for a given area of the state, are available to write public service and news materials for the media, to demonstrate to county and school nurses how to obtain immunization status data and maintain adequate records, to suggest ways to encourage a visit to a doctor for the necessary immunizations, and to explain the necessity of good community disease surveillance and the value of physician diagnosis.

Certainly a resurgence of rubeola in elementary school children is an obvious threat to the public health. It is the continuing desire of the Iowa State Department of Health to provide technical and advisory assistance to the private physician in this vital area.

IOWA Specialty Groups

IOWA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS . . . The annual University of Iowa Postgraduate Course and Fall Meeting of the Iowa Chapter of the American Academy of Pediatrics will take place in Iowa City September 19 and 20. Guest speakers will include Drs. Lewis Fraad, Dane Prugh and Eugene Ensminger. For information write Alfred Healy, M.D., or James A. Stehbens, Ph.D., Department of Pediatrics, University of Iowa College of Medicine, Iowa City, Iowa 52242.

IOWA ASSOCIATION OF PATHOLOGISTS . . . The following physicians were elected officers at recent Annual Meeting of the IAP: Willard S. Pheteplace, M.D., Davenport, president; Richard W. Adams, M.D., Des Moines, secretary-treasurer; and James D. Collins, M.D., Waterloo, president-elect.

AMERICAN COLLEGE OF PHYSICIANS . . . An Iowa Regional Meeting of the American College of Physicians occurred May 11 and 12 in Des Moines. The Iowa Clinical Society of Internal Medicine met in conjunction with the College's scientific session. Planning for the meeting was under the direction of Atlee B. Kendricks, M.D., Davenport, ACP Governor for the Iowa Region.

IOWA MEDICAL MISCELLANY

(Continued from page 263)

ALCOHOLISM MEETING . . . IMS Committee on Alcoholism was briefed May 23 on the alcohol treatment program at the Mental Health Institute in Cherokee.

PSYCHIATRIC CARE . . . Representatives of the state's four mental health institutes met May 30 with the IMS Subcommittee on Psychiatric Care at Society Headquarters.

IOWA PSYCHIATRIC SOCIETY . . . Spring Meeting of the IPS occurred May 19 in Des Moines with panel discussion on Peer Review and Professional Standards Review Organizations (PSRO) and Health Maintenance Organizations. Following notice has been submitted by the American Psychiatric Association Office of Continuing Medical Education: All psychiatrists who have not taken the Psychiatric Knowledge and Skills Self-Assessment Program are urged to apply for it by writing the APA. The test stresses patient management problems, allows participants to score themselves in relation to peers and offers credit in continuing medical education.

IOWA ACADEMY OF FAMILY PHYSICIANS . . . June 11, 12 and 13 are dates of the 15th Annual Spring Postgraduate Conference of the Iowa Academy of Family Physicians to be held at the New Inn at Lake Okoboji. The Iowa Heart Association will sponsor the first-day program. Lectures on various phases of medicine will be presented on the two remaining days. A May 10 seminar was held in Denison with lectures by a plastic surgeon, neurologist and a cardiologist.

OVER A MILLION . . . March was first month in which Blue Shield UCR contracts provided over $1 million in benefits. Better than 95% of the UCR claims were paid as submitted in the first three months of 1973.

OCCUPANCY . . . A 26-bed adult section of the Rubin H. Flocks Prostatic Disease Center was occupied in May at University Hospitals in Iowa City. An additional 15 beds for pediatric urology patients will be available soon. Center is named for IMS President Flocks.

About IOWA Physicians

Dr. Daniel Hunting has joined staff at Medical Center in Hartley for spring and part of summer months. A native of Cedar Rapids, Dr. Hunting received M.D. degree at U. of I. College of Medicine in 1972 and completed his internship at University Hospital in Iowa City. He plans to begin urology residency in September at Mayo Clinic in Rochester. . . . **Drs. Douglas Johnson, Frank Rogers** and **James Young,** Clinton, participated in IQ (I Quit) Smokers Clinic at Clinton's Mercy Hospital. Dr. Johnson spoke on psychological aspects of why people smoke; Dr. Rogers discussed smoking and the lungs; and Dr. Young summarized.

Dr. Harry Brom, D.O., Creston, was guest speaker at monthly meeting of Registered Nurses Association at Creston Medical Clinic. Dr. Brom described heart surgery he had undergone a year ago and discussed common factors of heart disease. . . . **Dr. Peter Vande Haar** joined **Drs. R. M. Collison, S. A. Smith,** and **Charles R. Argo** at Oskaloosa's Family Medical Center in April. Dr. Vande Haar received M.D. degree at U. of I. College of Medicine in 1971 and took postgraduate training at Northwestern University's Passavant Hospital. . . . **Dr. Robert M. Kretzschmar,** associate professor of obstetrics and gynecology at U. of I. College of Medicine, was guest speaker at recent meeting of Muscatine County Cancer Society. Dr. Kretzschmar is presently serving as professional delegate from Iowa Division to National Society. . . . **Dr. P. A. Nierling,** retired Cresco physician, has received "certificate of appreciation" for his 16 years of service as a Selective Service medical adviser.

Dr. Einer M. Juel, Atlantic, was re-elected president of board of directors of Southwest Iowa Mental Health Center, Inc., at ninth annual meeting of the group. . . . **Dr. Glendon Button,** Conrad, was guest speaker at recent meeting of Tryst Club in Eldora. Dr. Button's topic "How to Deal With Emergencies." . . . **Dr. John MacQueen,** associate dean of U. of I. College of Medicine, was main speaker at recent Health Conference in Carroll sponsored by Iowa Office of Comprehensive Health Planning and Tri-Valley Health Planning. Dr. MacQueen's talk was entitled, "A Concept for Delivery of Health Care and Medical Services." . . . **Dr. Chester F. McClure,** Decorah, participated in seminar on alcoholism and problem drinking in Decorah, co-sponsored by Northeast Iowa Mental Health Center and Office for Planning and Programming. Dr. McClure's topic "Alcohol, the Most Used and Misused Drug." . . . **Dr. Patrick H. Kain** will join **Drs. Dennis R. Olsen** and **James C. Carr** at Medical Associates in New Hampton in August. Dr. Kain is currently serving with Army as general medical officer at Darnall Army Hospital in Fort Hood, Texas. He will complete his military service in July. A native of Algona, Dr. Kain is 1970 graduate of U. of I. College of Medicine and served his internship at Broadlawns Hospital in Des Moines. . . . **Dr. John R. Doran,** Ames, was guest speaker at recent meeting of Webster City Women's Club. Dr. Doran's subject "Female Diseases."

Dr. S. P. Leinbach, Belmond, was keynote speaker at Annual Forum of Mental Health Center of North Iowa in Clear Lake. . . . **Dr. Adib Mikhail,** Cherokee Mental Health Institute, and native of Egypt, was recent speaker at Kiwanis luncheon in Cherokee. Dr. Mikhail traced Egyptian history with emphasis on the industrial growth since 1952. . . . **Dr. Nosrat Massih,** Council Bluffs cardiologist, spoke in Malvern recently on emergency cardiac resuscitation monitor soon to be available to residents of Council Bluffs area on 24-hour basis. . . . **Dr. Bruce R. Bedell** recently began practice of ophthalmology in Sioux City. Dr. Bedell

received M.D. degree at U. of I. College of Medicine and served his internship at Broadlawns Hospital in Des Moines. He completed his residency in ophthalmology at U. of I. and while in Iowa City, was post doctorate fellow in neuro-ophthalmology and an instructor in Department of Ophthalmology. . . . **Dr. Horst Blume,** Sioux City neurologist, was guest speaker at Multiple Sclerosis Area meeting in Sheldon. Dr. Blume is chairman of Northwest Iowa Chapter Medical Board. . . . **Dr. T. T. Bozek** has opened Family Practice Clinic in West Branch. The Clinic is located in new professional building erected by Dr. Bozek. Two attorneys occupy offices in building and space is available for a dental office.

Dr. Ralph Moress and **Dr. David Wetrich,** both of Ottumwa, were guest speakers at recent Ottumwa "Women Aware" program. The two physicians spoke on "Women's Physical and Emotional Health." . . . **Dr. Thomas E. Bergstrom** will join **Drs. Paul F. Chestnut, John E. Evans** and **Earl G. Rozeboom** in practice of medicine at Winterset in July. A native of Onawa, Iowa, Dr. Bergstrom received M.D. degree at U. of I. College of Medicine in 1972 and is completing his internship at University of Nebraska Hospital in Omaha. . . . **Dr. Richard Lawton,** Iowa City, president of the Kidney Foundation of Iowa, was guest speaker at recent Iowa State University meeting sponsored by Theta Lambda chapter of Beta Sigma Phi sorority. . . . **Dr. Charles Maplethorpe,** Toledo, won honors for best speaker at Tama-Toledo Toastmaster Club meeting in March.

Dr. S. Fred Brunk, associate professor in Department of Internal Medicine at U. of I. College of Medicine, is one of six U. S. physicians whose comments on management of Hodgkin's disease appeared in March 19 issue of MODERN MEDICINE. . . . **Dr. D. M. Tan Creti,** Denison, has been named to Crawford County Board of Health. . . . **Dr. Jayant Belsare** opened a practice of general surgery in Mt. Pleasant in March. Dr. Belsare received his medical training and served his internship in India. He served a residency in general surgery in Durham, North Carolina and at Johnston Willis Hospital in Richmond, Virginia. Dr. Belsare was a preceptee in general surgery in Mason City for six months and since June, 1971, has been in private practice in Clarinda. . . . **Dr. S. M. Haugland,** Lake Mills, was guest speaker at recent meeting of Mason City Chapter, American Association of Medical Assistants. . . . **Dr. Lloyd Spencer,** Cedar Falls, director of Black Hawk County Mental Health Center, spoke on "Medication and Hyperkinetic Child," at Cedar Falls meeting of Black Hawk County Association for Children with Learning Disabilities.

Dr. John Tyrrell, Manchester, discussed duties of Hoover Health Council at recent meeting of Manchester Lions Club. . . . **Dr. Charles Bendixen,** Marshalltown, was guest speaker at recent meeting of Marshalltown Evening Lions Club. He told of his experiences with group of flying physicians who made business and pleasure trip to Alaska. . . . **Dr. Eric M. Swanson,** Fort Dodge ophthalmologist, has been named city health physician. . . . **Dr. Richard M. Caplan,** assistant dean for continuing medical education at The U. of I., was guest speaker at March meeting of Johnson County Medical Society. Dr. Caplan's topic: "Quality Assurance Programs in Community Hospitals: What? Why? Who? How?"

Dr. and Mrs. Dallas Minchin, Council Bluffs, will accompany group of physicians and their wives on a world tour. Trip will include visits to hospitals and clinics in Moscow and opportunity to take course in acupuncture in Mongolia. . . . **Dr. and Mrs. John K. MacGregor,** Mason City, were guest speakers at recent meeting of Wapello County Medical Society. Dr. and Mrs. MacGregor discussed experiences at a Navajo Indian reservation in Arizona and showed a film on the Navajo territory. . . . **Dr. Fred G. Smith, Jr.,** has been named professor and head of pediatrics at U. of I. College of Medicine. Dr. Smith, now at UCLA, will assume his new duties June 25, succeeding **Dr. Donal Dunphy,** who has served as head of pediatrics since 1961. Dr. Dunphy will remain on U. of I. faculty as professor of pediatrics. At UCLA Dr. Smith is professor of pediatrics, chief of division of nephrology and director of the pediatrics resident training program. He received M.D. degree at UCLA and also completed his internship and residency there. In 1956-57, he was resident and fellow in nephrology at University of Minnesota. He joined



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UCLA faculty in 1960. . . . **Dr. John E. Evans,** Winterset, has been elected vice chairman of Madison County Board of Health.

Dr. H. J. Yehyawi, an obstetrician and gynecologist, has joined **Drs. Tomas Lopez** and **Joseph Rapagnani** in practice of medicine at Keokuk. Dr. Yehyawi received M.D. degree at University of Damascus in Syria. He served 2½ year residency in obstetrics and gynecology in England and completed his training in United States at New York Infirmary in New York City. Dr. Yehyawi has passed examination for certification by American Board of Obstetrics and Gynecology. . . . **Dr. Frank W. Reibold,** Carroll, attended a post-graduate pediatric course at Williamsburg, Virginia, sponsored by Virginia Commonwealth University. . . . **Dr. Gerald C. Miller,** Clarinda, was guest speaker at recent meeting of Medical Explorers in Clarinda. Dr. Miller spoke on hip pinning and gave general summary of events preceding surgery. . . . **Dr. James O. Stallings,** Des Moines, discussed "Flaps, Grafts and Flimflams" at recent Hardin County Medical Society meeting. He spoke on "Lyophilized Porcine Heterograft in Treatment of Split-Thickness Skin Graft Donor Sites," at a meeting of Cerro Gordo County Medical Society. Dr. Stallings also attended recent meeting of Military Society of Plastic Surgeons at Walter Reed General Hospital in Washington, D. C.

Dr. S. P. Leinbach, Belmond, was guest speaker at recent annual forum of Mental Health Center of North Iowa in Clear Lake. Dr. Leinbach's topic: "The Family Physician Shares His Views on Mental Health." . . . **Dr. Earl F. Rose,** professor in The U. of I. Pathology Department, spoke at recent meeting of Fifth District Iowa Nurses Association in Cedar Rapids. Dr. Rose's topic: "Suicide: A Mental Health and Legal Problem." . . . At April annual meeting of Iowa Urological Association, **Dr. A. Akbari,** Sioux City urologist, presented a paper on "Lower Urinary Tract Obstruction in Children." . . . **Dr. James D. Smith,** a U. of I. otolaryngology resident, is recipient of sixth annual Benjamin Shuster Memorial Award for outstanding research in head and neck plastic surgery. Award was given at annual meeting of American Academy of Facial Plastic and Reconstructive Surgery, Inc., in St. Louis.

State Representative Delwyn Stromer was guest speaker at April meeting of Wright County Medical Society. . . . **Dr. J. C. Justin,** Mason City, discussed rheumatic fever at recent meeting of Mason City Chapter of American Association of Medical Assistants. The program was arranged by Iowa Heart Association. . . . The new Williamsburg Clinic operated by U. of I. Family Practice Center opened April 1. Two Iowa City resident physicians, **Drs. Jack Brindley** and **Roger Willcox,** in addition to a faculty member, have been assigned to the clinic along with supporting personnel and a full-time nurse. . . . **Dr. S. M. Haugland,** Lake Mills, presented a program on human emotional problems at April meeting of Mason City Chapter of Medical Assistants. . . . **Dr. Carlyle Moore,** Emmetsburg, was guest speaker at capping ceremony for 1972-73 class of L.P.N's at Iowa Lakes Community College.

Dr. Arnold Reeve, Iowa Commissioner of Health, and **Dr. Herbert Gude,** Iowa Falls, were key speakers at April Venereal Disease Workshop at Ellsworth Community College in Iowa Falls. Dr. Reeve discussed the incidence and prevalence of venereal diseases and Dr. Gude described the role of the private physician and local treatment facilities. . . . **Dr. Clifford Rask,** Maquoketa, outlined danger signals and emphasized importance of early detection at a cancer education program offered in Bellevue by the women's auxiliary to local jaycees. . . . **Drs. John L. Bailey** and **Gerald F. Brown,** Anamosa, are constructing a 3-doctor clinic building adjoining the Anamosa Community Hospital. . . . **Dr. John Rawls,** Ottumwa, is new president of the Wapello County Medical Society. Other new officers include: **Dr. David W. Wetrich,** president-elect, and **Dr. Robert P. Meyers,** secretary-treasurer. Both are Ottumwa physicians.

Dr. Edward M. Alt began the practice of family medicine in Bedford in April. A graduate of Purdue University and Indiana University Medical School, Dr. Alt practiced 13 years at Munster, Indiana, a suburb of Chicago, before moving to Iowa. . . . **Dr. Einer M. Juel,** Atlantic, was re-elected president of the Board of Directors of Southwest Iowa Mental Health Center, Inc., at the group's ninth annual meeting. **Dr. John R. Hornberger,** Manning, was re-elected to the board. . . . **Dr. Ruby Cureg,** Des Moines pediatrician, was guest speaker at recent meeting of Urbandale Junior-Senior High PTA. Dr. Cureg spoke on "Alternatives for Parents." . . . **Dr. Richard L. Sedlacek,** Cedar Rapids, discussed his recent trip to Holmes County, Mississippi, at April meeting of Linn County Medical Assistants. . . . **Dr. and Mrs. John Jacquis,** Cedar Falls, gave an illustrated accounting of their medical experiences in Bangladesh to the Waterloo-Cedar Falls Chapter of Iowa Nurses Association.

Dr. Don G. Bock, Fort Dodge, **Dr. Dorothy Ehmke,** U. of I. College of Medicine pediatric cardiologist, and **Dr. Dale Harding,** Eagle Grove, vice president of Iowa Heart Association, participated in a spring workshop for Licensed Practical Nurses in Fort Dodge. Dr. Bock gave a presentation on "Overview Disorder of the Heart"; Dr. Ehmke discussed "Pediatric Cardiology Including Heart Screening," and Dr. Harding covered "The Healthy Heart." . . . The following Red Oak physicians have been cited by the Iowa Tuberculosis and Respiratory Diseases Association for medical support provided the Montgomery County Tuberculosis and Health Association in behalf of the county medical society—**Dr. H. C. Bastron, Dr. E. M. Sorensen, Dr. S. Rodmond Smith, Dr. Jack D. Fickel,** and **Dr. Glenn M. Skallerup.** . . . **Dr. James Coffey,** Emmetsburg, was guest speaker at recent meeting of Emmetsburg Friday Club. Dr. Coffey explained the coronary care center at Palo Alto County Hospital. . . . **Dr. William L. Yetter,** an Iowa City surgeon, was honored recently for his years of service to his patients and Mercy Hospital. Dr. Yetter, an Iowa City native, joined the Mercy staff in 1950.

Five Waterloo area physicians recently joined together formally to provide 24-hour emergency room service at Allen Memorial Hospital in Waterloo. They are **Dr. Floyd Rolfs,** Parkersburg; **Dr. Clinton E. Berryhill,** Readlyn, and **Drs. Warren Nash, Robert Hathaway** and **Vernon Plager,** all of Waterloo. Not all five will actually participate in providing service, but will assist in recruiting additional members for the continuous service. The newly organized medical body is called Emergency Medical Associates Professional Corporation and will

provide emergency room service with physicians on duty 24-hours-a-day 365-days-a-year at the hospital. Target date for beginning the service is October 1. . . . **Dr. J. M. Hennessey,** Manilla, gave a film presentation on venereal disease at recent meeting of the Manilla School Boosters. . . . **Dr. James O. Stallings,** Des Moines, has been elected member-at-large of board of directors of Des Moines, Hearing and Speech Center. . . . **Dr. Jack Frost,** with the Tri-State Dermatology Clinic in Dubuque, recently returned from 20-day tour of major European skin treatment centers. He participated in discussions of electro-surgical treatment of skin cancer in France, Germany and Italy. Dr. Frost lectured for four days at Institutio Dermapatico Del Immaculato Center for Skin Disease in Rome.

Dr. Dennis H. Kelly, Sr., Des Moines, recently received a certificate recognizing his 50 years as alumnus of Cook County Internship and Residency Association. Dr. Kelly served his residency at Cook County Hospital in 1922-1923. Dr. Kelly was accorded life membership in the Iowa Medical Society at recent session of IMS House of Delegates. . . . **Dr. Walter M. Block,** Cedar Rapids, was guest speaker at recent meeting of Iowa Nurses Association in Waterloo. Dr. Block presented two lectures—Recognition and Management of Children With Cerebral Dysfunctions; and Medical Aspects of Child With Specific Learning Disabilities. . . . The following Sioux City physicians were program participants in Sioux City Renal Disease Conference—**Drs. Edward Van Bramer, Richard Vaught, William Jackson, George G. Spellman** and **Robert Boldus. Dr. Joseph D. Schmidt,** associate professor in Department of Urology at U. of I. College of Medicine, also participated. . . . **Dr. Helen Barton,** Independence Mental Health Institute staff member, was guest speaker at recent meeting of Phi Chapter of Delta Kappa Gamma in Maynard. Dr. Barton's topic: "Women and Cultures."

Dr. C. A. Nicoll, Panora, will be active in the supervision and operation of new medical clinic to be constructed adjacent to Panora Care Center Nursing Home. The Clinic is being constructed by Central Iowa Medical Professional Corporation, which has built and staffed clinics at Adair, Baxter and Granger. **Dr. John Gustaf-**

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son, Des Moines, heads the corporation. . . . **Dr. F. J. Neglia,** Maxwell, received special recognition at Maxwell Awards Banquet in April. The Maxwell Education Association selects annually an outstanding citizen who has contributed significantly to the community's educational program. Dr. Neglia is a former school board member, physician for the football team, and has directed the immunization program for the Maxwell Schools. . . . Two Des Moines physicians, **Dr. Catherine Condon** and **Dr. John Kelley,** were guest speakers at 17th annual meeting in Des Moines of American Association of Medical Assistants, State of Iowa. Dr. Condon explained kidney dialysis and Dr. Kelley discussed government's role in medicine.

At Waterloo workshop sponsored by Nurses Association of American College of Obstetrics and Gynecology, **Dr. Herman Hein,** director of Iowa Perinatal Medicine Service at U. of I. College of Medicine, spoke on the "High Risk Infant," and **Dr. Charles DeProsse,** assistant professor in Department of Obstetrics and Gynecology, talked about "Teen-age Pregnancy." . . . **Dr. J. L. Banks** and **Dr. J. R. Van Tuyl,** who recently opened Northwest Medical Clinic in Cedar Rapids, have opened an additional clinic at Atkins. The two physicians will spend two and one-half days each week at the Atkins Clinic and hope within the next few months to be joined by a colleague from Minneapolis. . . . **Dr. G. J. Hruska,** Belmond, attended refresher course sponsored by Minnesota Academy of Family Physicians in Minneapolis. . . . **Dr. Charles Krause,** associate professor in Department of Otolaryngology and Maxillofacial Surgery at The U. of I., recently returned from Chungathra, India, following three weeks at Mar Thoma Hospital, an Episcopal Mission, where he performed several operations for cleft lip. . . . **Dr. William E. Owen,** St. Ansgar, attended recent American College of Surgeons' four-day course on injuries in St. Louis and an April anesthesia course at University of Kansas. . . . **Dr. Eleanor Roverud,** Carroll, participated in recent meeting of Carroll Toastmistress Club. Dr. Roverud's talk, "Facts About Fags," traced history of tobacco from 16th century and told of relation to medical illness. . . . **Dr. Richard Bealka,** Director of Cromwell Children Unit at Independence Mental Health Institute, was guest speaker at Iowa School Food Service Convention at Hilton Coliseum in Ames.

DEATHS

Dr. George M. Gibbs, 72, retired Burlington physician, died April 2 in Loma Linda, California. Dr. Gibbs received M.D. degree at Loma Linda University in 1934. Active in promoting immunization programs and other aspects of preventive medicine, he had served for many years as county health officer and medical director of county health unit. In 1972 Dr. Gibbs was presented a life membership in Des Moines County Society for Crippled Children and Adults. A past president of Des Moines County Medical Society, he was a member of Iowa Medical Society and American Medical Association.

Dr. C. G. Thomas, 85, Monticello physician for 57 years, died March 29 at John McDonald Hospital, four hours after the death of his wife, Eloise, 81. Dr. Thomas received M.D. degree at University of Illinois. He served as chief of staff for many years at John McDonald Hospital and was a longtime member of the hospital board and board of Monticello State Bank. Dr. Thomas was a member of Rotary Club, American Legion, and life member of Jones County Medical Society, Iowa Medical Society and American Medical Association.

Dr. George B. Bristow, 49, Osceola, was killed in an accident at Nassau, in Bahama Islands. Dr. and Mrs. Bristow were in Nassau attending 1973 Scientific Meeting of Iowa Medical Society. A native of Princeton, Missouri, Dr. Bristow received M.D. degree at University of Louisville in Louisville, Kentucky, in 1946. He served his internship and residency in surgery at Kansas City General Hospital. Prior to locating in Osceola in 1952, Dr. Bristow served two years in U. S. Air Force in California. He was a member of Iowa Medical Society and American Medical Association.

Dr. Clark N. Cooper, 68, Waterloo physician for 35 years, died April 7 at Naples, Florida, General Hospital. Dr. Cooper received M.D. degree at U. of I. College of Medicine in 1929, served his internship at Cincinnati General

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Hospital in Cincinnati, Ohio, and returned to Iowa City for his residency. A veteran of World War II, he served with the Navy in the Pacific and was cited for his participation in the assault of enemy-held Attu Island. Founder of Surgical and Orthopedic Associates in Waterloo, Dr. Cooper retired in 1968. He was a member of Iowa Medical Society and American Medical Association.

Dr. Angelo B. Barbieri, 72, of Marshalltown, died April 11 at Community Hospital East in Marshalltown. Dr. Barbieri received the M.D. degree at Genoa Medical School. He practiced medicine in Europe and then received his U. S. degree at American General Hospital in Chicago, Illinois. He practiced medicine in Garwin from 1946 to 1964, then relocated in Marshalltown where he practiced medicine until his retirement in 1972. Dr. Barbieri was a member of American College of Surgeons, Iowa Medical Society and American Medical Association.

Dr. George E. Morrissey, 58, of Davenport, died April 25 at St. Luke's Hospital. A 1939 graduate of U. of I. College of Medicine, Dr. Morrissey served his internship and residency at St. Joseph's Hospital in Paterson, New Jersey. He completed postgraduate work at Pennsylvania Hospital, Philadelphia, University Hospitals, Iowa City, and Cook County Hospital, Chicago, and began the practice of family medicine in Davenport in 1946. Dr. Morrissey served with the 24th Infantry during World War II in the southwest Pacific and was awarded the Silver Star. He was a member of National Association of Medical Historians of Iowa, former president of Mercy Hospital Staff and Scott County Medical Society, and member of Iowa Medical Society and American Medical Association.

Dr. Robert A. Wilcox, 54, director of Student Health at U. of I. College of Medicine, died May 16 while on vacation in Milan, Italy. Dr. Wilcox received the M.D. degree at U. of I. College of Medicine in 1948, and joined the U. of I. as an instructor in hygiene and preventive medicine in 1949. In 1958 he was appointed psychiatrist to the Student Health Service and named director in 1971. Dr. Wilcox was a member of American Medical Association, Iowa Medical Society, American College Health Association, American Psychiatric Association and National Board of Medical Examiners.

Medical Assistants

by TENORA MEYER, CMA

SALLY GESINK, 1973-74 PRESIDENT

Mrs. Sally Gesink of Sioux City became president of American Association of Medical Assistants, State of Iowa, Inc., on May 5, at the State Convention banquet in Des Moines.



Sally has worked 3 years for Manou C. Atash, M.D., General Surgeon, 1010 Badgerow Building, Sioux City, Iowa. She previously worked in the office of a general practitioner for 4½ years.

Sally has been a member of the Sioux City chapter 7 years. She served as vice president for 2 years and president for 1 year. On the state level she has been vice president and president-elect. She has also been a member of the Education Committee.

Her husband, Burt, is employed by ITT Continental Baking Company and they have three children: Deanna, who will graduate in June from St. Luke's School of Nursing, Sioux City; Debbie (Mrs. Terry Nicoson of Spirit Lake, Iowa), who also attends college; and Scott, a student at North High School in Sioux City. They are active members of the First Presbyterian Church.

Like all our leaders in the medical assistants' organization, Sally is active, busy and has many hobbies. Among these she lists antiques, needlepoint and yard work. "Weed pulling" is an enjoyable diversion for Sally, indicating her interest in the "good things in life" and weeding out the undesirable.

SALLY'S ACCEPTANCE SPEECH

"Tonight it is with pleasure and gratitude that I accept the honor you have bestowed upon me; and for those who share the dream of a better AAMA of Iowa with me, I urge perseverance and courage.

"As we have experienced in the past, the rewards can be stimulating and gratifying and my hope is that as delegates we can spark a fire of enthusiasm among ourselves and rekindle this in our local chapters to keep this flame from fading, for it is so vital when we think in terms of *communication, awareness, education* and *growth!*

"A successful salesman must be enthusiastic and believe in the integrity of his product, and since we believe in the purity of our mission, let us sell AAMA proudly.

"Our profession includes many who have not heard of our organization; therefore, it is our responsibility to introduce them to our concepts, our programs and benefits. Let us not leave recruitment to our membership committees alone, but become mutually involved.

"Most of us possess new ideas and special talents and I encourage you to contribute of your talents and know-how fearlessly to enlarge our organization. 'Forward is the direction and fearless should be our attitude and progress the goal!'

"Today's demands, it seems, are directed so much toward our wages, working conditions and fringe benefits. Should not we as medical assistants also be concerned with the quality of our work and our educational improvement?

"Once again let each of us spark the fire of enthusiasm and persuade our fellow members and ourselves to acquire a better education in becoming a *Certified Medical Assistant.*"

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

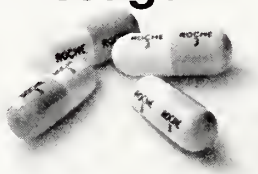
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Contraindications: Patient [illegible] hypersensitivity to the drug.

Warnings: Caution patient[illegible] combined effects with alcohol and [illegible] depressants. As with all CNS-acti[illegible] patients against hazardous occupa[illegible] complete mental alertness (*e.g.*, o[illegible] ery, driving). Though physical ar[illegible] dependence have rarely been repo[illegible] mended doses, use caution in adm[illegible] addiction-prone individuals or th[illegible] increase dosage; withdrawal sym[illegible] convulsions), following discontin[illegible] drug and similar to those seen wi[illegible] have been reported. Use of any d[illegible] lactation, or in women of childbe[illegible] that its potential benefits be weig[illegible] possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page



The July issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY serves by custom as the historical chronicle for our policy-making House of Delegates. On the ensuing pages you'll find reported the official 1972-73 activity of the Society leading up to and during the April sessions of the House of Delegates.

These proceedings in printed form have an obvious high value from the reference standpoint. But, in addition, to the casual member whose opportunity for participation has been limited, a skimming of the following pages, which contain committee reports, board reports and reference committee reports, will be most beneficial in terms of securing an overview of the Society's accomplishments, problems and challenges. I hope you'll take time to review the material.

County society delegates to the IMS House have a first-line responsibility to be informed on these matters. Please direct any follow-up inquiries you may have to them or to IMS Headquarters.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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President's Address

Professionalism, Credibility and Unity

K. E. LISTER, M.D.
Ottumwa

I APPRECIATE THIS OPPORTUNITY to address the 1973 House of Delegates. Traditionally, Society presidents have recounted their stewardship at one of the general sessions. But because we have revamped our meeting format this year, I come before you at this new time. Actually, I believe there is more logic in the President reporting to the House in this manner.

This is Des Moines' day for setting records. I refer to the Drake Relays where record performances are frequent and welcomed. Such names as Jesse Owens, Jim Ryan, Bobby Hayes, and Glen Cunningham are well known to us. These champions exemplify man's will to equal and surpass his rivals; this strong desire can and should be a force for good. We shouldn't restrict running the good race to track and field, not in the figurative sense, anyway. The analogy is applicable to many aspects of life, including the medical profession.

I head into my gun lap this afternoon. In doing so I plan to break the runner's rule and look back at the ground we have covered. Be assured though, when we pass the baton to end the 1972-73 leg of the Society's ongoing race, I'll be looking ahead expectantly at what the future holds. My personal observations of the Iowa Medical Society go back approximately 25 years. In this period I'm pleased to have served on various committees, as a Judicial Council member, as a member and chairman of the Board of Trustees, as President-Elect, and now as President. What assessment would I make of the Society and its performance over this period?

RECORD PERFORMANCE

Since track and field is our theme, I'd liken it to the sub-4 minute mile. In other words, I would submit that the Iowa Medical Society has turned in a record performance over the past 25 years. We've out-distanced state medical societies of equal size, and we've challenged the performance of many larger ones. These are boastful declarations, I agree. But I'd like to support my contentions by providing a sort of hopscotch analysis of what the dues-paying member has received for his investment in the Iowa Medical Society. As elected policy-makers, you delegates are presumably medicine's first-line advocates of professional organization and unity. Thus you have a right and a responsibility to know the "has done," "is doing," and "will do" aspects of the Iowa Medical Society. You, of course, have the further responsibility, which you are discharging here this weekend, to determine the Society's strategy for the next leg of the race. And, you have the additional and all-important task of interpreting our strategy at the local level.

Veteran members of this House know full well the instrumental part the Iowa Medical Society has played in thwarting the various national health schemes which have been ad-

(Please turn to page 292)

This address was delivered by Dr. Lister on April 28 during the opening session of the 1973 Annual Meeting of Iowa Medical Society House of Delegates.

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005

P·M·A

PRESIDENT'S ADDRESS

(Continued from page 289)

vanced over nearly three decades. We've given speeches, we've run ads, we've been to Washington, we've exerted our influence in countless ways in line with directives from this House of Delegates and from the Executive Council. Our performance on this broad front has been and is good.

There is today no total compulsory health insurance system in this country. And we are proud to say the Iowa Medical Society has been a strong advocate of the free and private approach to health care.

The changing times must be acknowledged however. Over the last 20 years, various phenomena have had an impact on public attitude, on congressional attitude, on the physician's image, on the support of our health care allies, on the involvement of organized labor, and so forth. Expert observers predict that some form of national health insurance is inevitable; they say it's just a matter now of how soon and in what form. What do we do in light of these conditions? We can assume a posture of total opposition to any and all further governmental involvement in health care; this is an appealing choice, but it's both unrealistic and it demonstrates a grave lack of concern for our patients and our profession, if I read the signs with any degree of perception. Another option is to go to bat for a national health care program wherein the public and the profession can exchange needs for services with the individual's financial circumstances determining the degree of government involvement. This philosophy is embodied in the Medicredit proposal which I believe will be drawn to your attention in the report of the Legislative Committee.

MEDICREDIT FEATURES

Medicredit does not disturb the Medicare program for the elderly. But it does replace Medicaid. Medicredit makes available to those under 65 a private program of comprehensive medical and health care protection to cover both ordinary and catastrophic expenses of an illness or accident. The individual or family protection desired may be elected from several options approved at the state level in accordance with national standards. For low income persons, unable to purchase protection for themselves and their dependents, the federal government would support the total premium of membership cost. For persons whose income is higher, the federal contribution is determined from a specified sliding scale based on income tax computation.

Where will Iowa physicians line up when this new chapter in national health care comes to a focal point? I hope our posture will be as it has been, the same as it was in 1964 when Iowa's Donovan Ward, as President of the AMA, was stumping for the nation's physicians, opposing Medicare, and supporting medicine's Eldercare option. The Iowa Medical Society's performance during this period was forceful, positive and rewarding, if not totally victorious. We did preserve several significant principles, namely: freedom of choice of physician; required use of private intermediaries; usual, customary and reasonable fees; direct billing options for physicians. Iowa Medical Society persistence and leadership came to the fore, particularly in securing the last two provisions. Medicaid, similarly, has the freedom of choice and usual, customary and reasonable options, but it sacrifices the direct billing option, partly because of organized medicine's earlier efforts (in Iowa and nationally) to be responsive to member wishes.

VENDOR PAYMENT

Let me recall this particular chapter from Iowa Medical Society history. In the 1950s, when medical grants were made directly to welfare recipients, they often ended up being used for other than their intended purpose. To overcome this problem, legislation was sought to make it possible for physicians to be paid directly for services provided these individuals. This response to a recommendation made by the House of Delegates marked the beginning of the vendor payment or assignment concept. This action was controversial then and remains so today. Vendor payment has its virtue and its shortcoming, as we now know. This precedent had a definite bearing on the more recent requirement that Medicaid payments be exclusively on an assignment basis.

In recent years the influence, the clout, pres-

tige, whatever you want to call it, of the Iowa Medical Society has brought to member physicians a much more equitable reimbursement for their services. The Society has battled aggressively for the fullest possible implementation of the usual, customary and reasonable fee philosophy, nationally and within the state. In its supervision of MAA and now Medicaid, the State Department of Social Services at various times has had to impose curtailments. It has advocated fee reductions on several occasions. The Iowa Medical Society has reacted strongly to these proposals and has resisted them successfully. Services have been reduced to extend limited appropriations, but fees have been held in line.

MEDICINE'S VOICE

This long involvement of the Medical Society in the legislative and socio-economic arenas has made it the recognized advocate for Iowa physicians. As the voice of Iowa medicine, merging the various specialty interests, the Society is the profession's principal intermediary with Blue Shield, with the private insurance industry, and with the federal and state governments. The importance of this liaison in terms of patient care, physician reimbursement, and the total health care delivery scene, is vital to you and your colleagues back home.

I mentioned Blue Shield, and it deserves special reference. The IMS deeply involved itself in enabling legislation which created Blue Cross 30 years ago. Similarly, at the direction of the House of Delegates, the IMS used its resources and legislative influence to establish Blue Shield. The Blues were regarded in the early days as a deterrent to a compulsory health insurance program, as well as a mechanism to pay physicians directly for their services. Development, implementation and expansion of Blue Shield have drawn heavily on the resources and manpower of the IMS through the years. Each House of Delegates has rightfully insisted that new programs proposed by Blue Shield be scrutinized carefully by the Society and have the benefit of maximum medical input. The time and energy devoted to this end are beyond measurement; the results, however, while controversial at times, have been positive. Bear in mind, too, the magnitude of Blue Shield—it now has more than one million subscribers in Iowa.

What's been accomplished by the Society more recently? Many of the things I've mentioned are ongoing. Let me cite other activities initiated in recent years and carried on this year. These illustrations may help us see our professional organization as one which is dynamic and responsive to the wishes of its member physicians.

PEER REVIEW

1) *We've formalized the peer review process* at the behest of the House of Delegates. The goal of this energetic effort has been to assure fairness in all aspects of medical care delivery. The program was established on a district basis with physician review of questions referred by third parties.

2) Taking this a step further, we've established the *Iowa Foundation for Medical Care* and it is functioning effectively. The Foundation will broaden even further the profession's involvement in the delivery and assessment of quality care. Its advent came after considerable exposure of the concept around the state and after extensive deliberation by the House. The Foundation's progress has been good and its role appears likely to exceed even preliminary expectations with the recent passage of HR1 and the professional standards review organization requirements contained therein.

REAPPORTIONMENT

3) We have before us the important matter of *reapportionment*. This is important to the Society in general and to this House of Delegates specifically. To be presented to you at this session is a proposal from the special Committee on House of Delegates Apportionment which realigns this policymaking body and enables all component societies, both with small and large numbers of physicians, to have an active involvement in the future of organized medicine in Iowa. Because of its vital nature, it is the recommendation of the Committee that the proposal lay over until an anticipated regular meeting of the House in the Fall to allow ample opportunity for discussion at the local level.

4) We've separated the *scientific sessions and the business meetings of the House of Delegates* this year for the first time. This is an obvious effort to give these two facets of the Society's

total program the separate prominence they deserve, and hopefully make them more attractive to those involved in terms of time, location, etc. The matters of continuing education and policymaking are principal reasons we have a professional organization.

5) In the legislative realm, we've seen *health maintenance organizations* occupy a top perch for several years. The Society has supported HMO enabling legislation in the belief that experimentation with this approach is in order. We have stated our position on the health maintenance organization to the general public and to Iowa's lawmakers. The current Iowa General Assembly has accepted some of our admonitions regarding HMO's, but it has left optional physician reimbursement (salary or contract), noting it in the measure which has passed the House and Senate as an exception to the corporate practice rule. I believe most of us tend to agree that HMO's, except in perhaps one or two settings, do not offer great promise here in Iowa or maybe elsewhere. Time will tell.

HOPSCOTCH REVIEW

This hopscotch review of both recent and more distant history is intended to make us mindful of what the Society has been and is involved in, in behalf of the public and the profession. Such a review is appropriate as we begin our policy making tasks. No claim has been made that every past action or decision was precisely the right one. My principal objective in taking your time to review Society activities has been to demonstrate the breadth and importance of the involvement.

Certain key words are prominent when we peer down the track into the future. Words such as professionalism, credibility, image, consumerism, and unity. These words characterize our areas of future concentration if we are to measure up to our own and the public's demands.

Only through the last of these words—unity—can we hope and expect to achieve the others. One of our colleagues—a man gifted with the pen—has in recent months written an essay or editorial on the subject of physician unity. It was published first in the Society's JOURNAL, then in the AMERICAN MEDICAL NEWS, and subsequently in several other journals. I'd like to go across the finish line by reading the excellent thoughts of Doctor James Bishop:

"Somewhere in the misty past, man learned that, by joining with his fellows, he could benefit more from the combined efforts of all than from his striving alone. The group, acting in unison, was more effective than each individual trying to function by himself. This 'herd instinct' caused man, collectively, to form tribes, villages, cities, nations, and even associations of nations.

GATHER TOGETHER

"As society has become more complex, the same 'herd instinct' has continued to manifest itself as people with common interest or occupations gather themselves into groups to better work toward their goals. The group, then, speaking in a single, loud voice, can be much better heard than many faint voices in the incessant din of today's society.

"Physicians have gathered themselves in a variety of groups, many based upon medical specialities. These societies are indispensable in the maintenance of modern professional skills, but few of them can exert much influence in the overall space of today's society. The direction in which modern society moves is determined by the sum of powerful conflicting pressures and tensions. Those who do not band themselves together to espouse their cause will find they have little influence upon the outcome.

ONE COMMON VOICE

"The one common ground upon which all physicians of all disciplines can meet to exert influence is organized medicine with its county, state and national components. It is the only common voice we have and its strength depends upon the support of its members. This voice does not always say what every member wants it to because there are healthy disagreements in any vigorous, democratic organization. The words the voice speaks will change whenever a majority wills it. It is far better that those who disagree try to change the words instead of withdrawing in pique and outrage to become, then, faint and querulous voices in the background. In the radically changing scene of medical care there is too much at stake, for patients and physicians alike, for us to impair our strength with petty divisions. . . ."

Presenting A United Front

RAYMOND T. HOLDEN, M.D.
Washington, D. C.

TODAY, more than ever, unity among physicians is essential. The problems confronting organized medicine, at the county level, state-wide, as well as nationally, are strikingly similar. There are no problems confined to a single geographic area. What is done in Washington affects you, and what your legislature does has an effect or influence in Washington.

Differences between national organizations and their components are bound to occur, but they furnish the fuel from which innovative ideas are formed and creative thoughts grow. We do not expect unison, but we do expect unity. Either we will be stronger than our common problems or they will overcome us.

As you deal with your problems at the state level, we, at the national level, are directing our efforts to solutions there. You are making a direct contribution to the solutions of problems at the national level through your participation in the AMA House of Delegates.

Drs. Herman Smith, Leslie Swanson and Elmer Smith are well-respected members of our House, and I regret to hear Dr. Elmer Smith is retiring, but I am sure you will put a capable successor in his place. Your President-elect, Dr. Rubin Flocks, serves on the Inter-specialty Council. Last year he was the Vice Chairman of that Council, and he also serves on committees of the Council on Medical Education.

My good friend Dr. Donovan Ward was President of the American Medical Association in the not too distant past.

Dr. Holden is a member of the Board of Trustees of the American Medical Association. He practices obstetrics and gynecology in Washington, D. C. He made the remarks to the IMS House of Delegates on April 28, 1973.

SIMILAR PROBLEMS

Now, in reviewing your HANDBOOK, prior to coming here, it was interesting to note the similarity of problems which exist here and those which exist in other places I have been. As I visit the component societies, I find that PSRO, national health insurance, HMO's, Phase III, manpower, membership, unions are the issues raised everywhere. I am happy to note that you have directed your Foundation for Medical Care to seek recognition as a PSRO.

What is a PSRO? It is an organization representing a substantial portion of the practicing physicians which will assume responsibility in local areas designated by the Secretary of HEW by January 1, 1974, for comprehensive and ongoing review of services granted under Medicare and Medicaid.

These reviews are to determine:

1. If the services are medically necessary.
2. If the services met appropriate professional standards.
3. If the services, in the case of in-patients, could have been provided more economically in another facility or maybe on an out-patient basis.

Only organizations representing a substantial portion of the physicians in the area will be allowed to establish PSRO's until 1976. This in effect gives physicians a monopoly in this field through 1975, and I can't impress that on you enough. The medical profession has a monopoly in this field of PSRO's for the next two years. No one else can enter. After 1975—that is, 31 December 1975—the Secretary of HEW may contract with other groups for performance or review, but only after determining that local professional groups are unable or unwilling to perform the review functions.

AMA INVOLVED

PSRO's will be limited initially to reviewing health care provided by or in institutions and may assume the review of other services only with approval of the Secretary. The AMA House of Delegates has agreed with the Board of Trustees and with the Council on Medical Service in directing that PSRO's being an accomplished fact, should get full cooperation from the AMA.

You realize the AMA did not originally support PSRO. We had a draft bill which was introduced in Congress on the Peer Review Organization Act which was a companion to our Medicredit proposal. It didn't get very far because Senator Bennett was able to muster a great deal of support for his amendment to the large HR-1, so that amendment is the law which we operate under at this time. However, we were successful in getting some very important changes made in the original wording of the Bennett Amendment and these resulted in marked improvement in the present law from our standpoint.

These changes included:

1. Elimination of the provision for pre-admission certification.
2. Establishment of norms for health care on a regional basis rather than on a national basis.
3. Elimination of the criminal penalty and the monetary liability or fine for non-conformance or non-compliance with the law.
4. Retention of the ownership of the records and the profiles of both patients and physicians in the hands of the local organizations rather than letting them become the property of the national government and be part of the SSA organization.

We were unsuccessful in having medical societies designated as PSRO's.

ESTABLISH ADVISORY COMMITTEE

Now, the AMA has established an advisory committee composed of representatives from its committees and councils as well as other interested organizations. This committee is supported by a task force of experts in all fields. It will assist in the formation of PSRO's. It will work closely with the Director of the PSRO program, Dr. William Bauer. And Dr. Bauer's organization, by the way, is still in the formative stage. The PSRO Council, which is to be a government council advisory to Dr. Bauer, has not yet been formed. I am told, and very reliably, that we will have representation on this council.

If the PSRO's should fail because of failure of cooperation by the medical profession, what are some of the alternatives?

1. Hospitals could organize to assume the responsibility, which would make physicians their subordinates in the application of standards of review.
2. The Congress could establish a bureaucracy of laymen to handle PSRO. That possibility was very narrowly averted when the AMA was successful in having the legislation amended to its present form.

Peer review, claims review and utilization review are not new to us. They should have no fears for us. The option which the AMA has chosen—that is, to cooperate fully under the existing law—is the best one available, and we must make it work, both for our patients as well as ourselves, or we will lose the hold we have.

Now, your Committee on Legislation has advised you that action on national health insurance is unlikely before the second session of the 93rd Congress—that is, before 1974. Our intelligence agrees with that.

IMPROVED MEDICREDIT

We are also informed that whatever bill is enacted or is seriously considered will be tailored to meet the funds available. In this regard, AMA has introduced its improved Medicredit bill, the national health insurance proposal of 1973. This is firm evidence of the profession's avowed interest in the financing of and access to health care.

To date, we have 175 sponsors for this bill—more than any other health proposal in Congress—and, I am happy to say, the three Republican congressmen from Iowa have signed as sponsors of this bill. Support of this and other AMA drafted legislation is a place for united action.

Now, HMO's are being considered prominently in this Congress. To you and me HMO is just a term for pre-paid group practice. It has no special magic. Its physicians are no more expert, no more knowledgeable, no more

dedicated than any other physician. They can't do a thing you or I can't do. We have been familiar with this in one form or another for years, yet it has suddenly been proclaimed as a panacea for all the problems of health care.

Senator Kennedy has introduced a bill which would blanket the country with federally subsidized HMO's. This bill has been reported out of the subcommittee on health in the Senate, and, after the Easter recess of Congress, it could be on the Senate floor any day, and it has an excellent chance of passing the Senate. Last year it passed the Senate by a vote of 64 to 14, so you see it has an excellent chance of passing again this year; we hope to reduce the size of the majority.

The Administration has taken another look at HMO's and offers a very limited bill in this field. This is a far different attitude from the one which the Administration displayed in 1971. The bill introduced by Congressman Rogers of Florida and Congressman Roy of Kansas is much more comprehensive than the Administration bill, but it is far more limited than the Kennedy bill.

AMA ON HMO

The AMA's position on HMO's is well-known. HMO is just one method for the delivery of health care. When established with private funds, it is considered no different from any other type of group practice. Government funding of HMO's should be limited to experimental models for a specified time to demonstrate their utility. The AMA has taken a strong stand against the Kennedy bill. United action and opinion is again necessary.

Phase III continues to rankle us. In view of the good performance of the profession in Phases I and II the discriminatory inclusion of physicians in Phase III is unwarranted and unfair. The AMA has protested this to the President. Our Board Chairman, Dr. John Kernodle, met with Mr. Nixon on March 30, 1973, and subsequently with Mr. John Dunlap, Chairman of the Cost of Living Council. This was at the President's direction in an effort to resolve the situation. With the things that are going on in Washington, though, it is taking a back place —back burner on the stove—but we will get action. As a matter of fact, there is some stirring going on, but what will come of this, I don't know.

Here in Iowa you even have another problem because they tack it on to your beef and pork, and so on, so you have something else to gripe about, too.

MEMBERSHIP

Membership is of interest to all of us. National and state associations must grow to keep alive. I am happy to hear of the active membership recruitment drive which is under way in the IMS.

Now, AMA membership was up in 1972, and for the first quarter in 1973, 40 states have enrolled more members than they had at that period of time in 1972, so we are considerably ahead of our 1972 membership enrollment at this time of the year. We hope this trend continues and increases.

Interns and residents are now seated in our House of Delegates. Students will be in June. These are segments of the profession to which we should open our doors and our hearts widely, as they are our future. We all have an interest in the future.

UNION MOVEMENT

Development of the union movement in the profession has been of concern to the Board of Trustees. We appreciate and respect the right of any individual to align himself with any organization of his choice. It is easy to understand a person's reaction when he feels oppressed or coerced, but, in reacting, one should remember that the American Medical Association is not the enemy and name does not carry privilege. There is no magic in the word "union," and organizations of physicians, self-designated as a union, do not possess superior legal tools with which to serve physicians. The American Medical Association and its constituent and component societies can do anything legal for its members that a union can do. They normally use the energy and enthusiasm which might otherwise be channeled into these new organizations.

In closing, may I leave one thought. We are all practicing physicians. Nationwide our hopes, desires and problems are similar. We must preserve the dignity of our profession and we must present a united front in facing that challenge.

A GLIMPSE AT THE IOWA MEDICAL SOCIETY

WHAT IS THE IOWA MEDICAL SOCIETY?

This question is asked frequently by interested Iowans who have had little or no opportunity to be in direct contact with the Society. It's a legitimate inquiry and one which requires some time and space to answer adequately.

We offer this five-point synopsis of the Society as at least an introductory response. We are placing particular emphasis here on the identification of the 1973-74 leadership, for it is these physicians who have major responsibility for the operation of the Society.

PURPOSES

The following are principal among the Iowa Medical Society's stated reasons for existing:

- To promote, extend, elevate and advance medical science and medical knowledge.
- To advocate such measures as will tend to alleviate the sufferings, improve the health and protect the lives of human beings.
- To promote the science and art of medicine and the betterment of public health.
- To federate, bring together and organize the medical profession of the State of Iowa, uniting with similar associations in other states to form, and be part of, the American Medical Association.
- To elevate the standards of medical education, to assist worthy and deserving medical students by establishing loan funds or being the trustee of scholarship funds.
- To enact and enforce just medical laws.
- To establish, maintain and enforce as an incidence to membership, high standards of professional conduct and ethics, these purposes to the end that the profession shall become more capable and honorable within itself and more useful to the public, thereby prolonging and adding comfort to life.

These high aims exist as the foundation on which rests the organizational superstructure of the medical profession in Iowa.

ORGANIZATION

The Iowa Medical Society has a House of Delegates as its legislative or policy-making body. This House includes approximately 150 physicians selected individually by the 93 constituent county medical societies (several societies include two counties). The delegates meet formally at least once a year to act on important matters and to chart the Society's course for the ensuing year. In between sessions of the House an Executive Council of the Society is empowered to consider and decide on pressing issues. An eight-member Board of Trustees exercises the executive powers of the Society, which include fiscal management, administrative staff supervision, etc. Twelve other Iowa physicians comprise a Judicial Council which hears and resolves matters concerning ethics and discipline.

In addition to these principal components of the Society, about 50 committees of physicians exist to study issues in specific areas, to devise programs and to make recommendations.

The Society's organizational activity may be divided broadly into four areas: medical service, medical education, legislation and public relations.

MEMBERSHIP

In the most recent formal membership report made to the Iowa Medical Society House of Delegates, 2,226 physicians were noted as being active members of the Society. This figure includes more than 90 per cent of the physicians in Iowa.

To be an active member of the Iowa Medical Society, a physician must (1) be properly licensed to practice in Iowa, (2) hold an appropriate medical or osteopathic degree, (3) be an active member in good standing of his county medical society, (4) be approved by the Society's Judicial Council, and (5) have submitted his current dues.

IN THE PUBLIC INTEREST

IOWA MEDICAL SOCIETY LEADERSHIP

The Iowa Medical Society organizational year begins each spring following the Annual Session of the House of Delegates. Officers elected by the House become active at this time and serve their specified terms. The principal Society officers for 1973-74 are:

President—R. H. Flocks, M.D., Iowa City
President-Elect—R. L. Wicks, M.D., Boone
Vice President—R. M. Chapman, M.D., Cedar Rapids
Secretary—V. L. Schlaser, M.D., Des Moines
Treasurer—T. A. Burcham, M.D., Des Moines
Trustee & Board Chairman—J. F. Bishop, M.D., Davenport
Trustee—J. F. Paulson, M.D., Mason City
Trustee—A. J. Havlik, M.D., Tama

District Councilors serve in behalf of specified counties and form the Judicial Council:

District 1—C. L. Kelly, Jr., M.D., Charles City *(Mitchell, Howard, Winneshiek, Allamakee, Floyd, Chickasaw, Fayette, Clayton and Bremer)*

District 2—H. G. Marinos, M.D., Mason City *(Kossuth, Winnebago, Worth, Hancock, Cerro Gordo, Humboldt, Wright, Franklin and Butler)*

District 3—J. M. Rhodes, Sr., M.D., Pocahontas *(Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto and Pocahontas)*

District 4—D. M. Youngblade, M.D., Sioux City *(Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Sac, Monona, Crawford and Carroll)*

District 5—C. H. Denser, Jr., M.D., Des Moines *(Polk and Warren)*

District 6—A. M. Dolan, M.D., Waterloo *(Hardin, Grundy, Black Hawk, Marshall, Tama, Benton, Jasper, Poweshiek and Iowa)*

District 7—J. E. Tyrrell, M.D., Manchester *(Buchanan, Delaware, Dubuque, Linn, Jones, Jackson, Johnson, Cedar and Clinton)*

District 8—J. F. Collins, M.D., Davenport *(Washington, Muscatine, Scott, Jefferson, Henry, Louisa, Van Buren, Lee and Des Moines)*

District 9—K. A. Garber, M.D., Corydon *(Marion, Mahaska, Keokuk, Lucas, Monroe, Wapello, Wayne, Appanoose and Davis)*

District 10—E. E. Gamet, M.D., Lamoni *(Adair, Madison, Adams, Union, Clarke, Taylor, Ringgold and Decatur)*

District 11—Hormoz Rassekh, M.D., Council Bluffs *(Harrison, Shelby, Audubon, Pottawattamie, Cass, Mills, Montgomery, Fremont and Page)*

District 12—E. E. Linder, M.D., Ogden *(Calhoun, Webster, Hamilton, Greene, Boone, Story, Guthrie and Dallas)*

Delegates to AMA—L. W. Swanson, M.D., Mason City; H. J. Smith, M.D., Des Moines, and E. M. Smith, M.D., Des Moines *(Term expires 12/31/73)*

Alternate Delegates to AMA—C. E. Radcliffe, M.D., Iowa City *(Becomes delegate to succeed E. M. Smith, M.D., 1/1/74)* **Terms begin 1/1/74 for J. R. Anderson, M.D., Boone, Erling Larson, Jr., M.D., Davenport, and J. M. Rhodes, Sr., M.D., Pocahontas**

Speaker, House of Delegates—L. D. Caraway, M.D., Amana

Vice Speaker, House of Delegates—R. D. Whinery, M.D., Iowa City

Blue Shield Liaison Delegates to IMS—S. P. Leinbach, M.D., Belmond, and C. W. Seibert, M.D., Waterloo

Immediate Past President—K. E. Lister, M.D., Ottumwa

IOWA MEDICAL SOCIETY HEADQUARTERS

While the membership is obviously distributed across the state, the Headquarters of the Iowa Medical Society is located at 1001 Grand Avenue, West Des Moines, Iowa 50265. It is here that council, board and committee meetings are held and day-to-day administrative functions are performed. A variety of health projects are coordinated from IMS Headquarters. Requests for further information on Society Activities may be directed to IMS.

State Department of Health

ARNOLD M. REEVE, M.D., M.P.H., Commissioner

IOWA'S PROGRAM OF DIAGNOSTIC BACTERIOLOGY FOR GONORRHEA

The Iowa Department of Health, in cooperation with the State Hygienic Laboratory and other selected laboratories in the state, is initiating a bacteriologic culture service to aid physicians in the detection and diagnosis of gonorrhea.

Since gonorrhea is usually asymptomatic in the female, laboratory assistance is needed for detection and positive diagnosis. Less than 20% of females with gonorrhea have any noticeable signs or symptoms in the early stages. The most reliable method for detecting gonorrhea in the female is bacteriologic culture. Gram-stain smears are not recommended for diagnosis of gonorrhea in women.

In males the presence of Gram-negative intracellular diplococci in smears of urethral exudate still constitute sufficient basis for a diagnosis of most cases of gonorrhea. Extracellular diplococci may be observed in very early or late (chronic) gonorrhea in the male. Smears should be prepared by rolling the swab on the slide. DO NOT RUB the swab NOR HEAT FIX the smear as these procedures could distort the microscopic morphology. Males should be cultured (1) in cases of extra genital gonorrhea (rectal, pharyngeal), (2) in medicolegal situation, or (3) when smear procedures are negative in the presence of clinical or epidemiologic findings.

Because the gonorrhea organism is quite fragile and does not survive transportation in commonly used types of culture media, a new transport medium, "Transgrow," has been developed. By using a cotton tipped swab a physician can inoculate Transgrow media in his office or clinic and mail it to the laboratory for examination. While the organisms will multiply in Transgrow at room temperature, more accurate results are obtained when the specimens are incubated at 37°C overnight before mailing to the laboratory.

Physicians wishing to use the bacteriologic culture service may contact the State Hygienic Laboratory, Medical Laboratories, State University of Iowa, Iowa City, Iowa 52240 (319-353-5990), and request the estimated number of bottles of Transgrow media needed for a month. The Transgrow media will be sent to the physicians with mailing containers which may be used to return the inoculated media to the laboratory. There is no charge to physicians or patients for this service.

A program using Thayer-Martin media will be available in the future to physicians in selected cities in which there is a cooperating laboratory. Physicians in these communities will be notified when this aspect of the program is operational.

Information about the technique of collecting specimens for culture may be obtained from the Iowa State Department of Health, Venereal Disease Division, Lucas Office Building, Des Moines, Iowa 50319 (515-281-3031), or the State Hygienic Laboratory of The University of Iowa (319-353-5990). In addition public health representatives from the Department of Health will be calling on physicians to provide additional information about this new service and the other services of the Venereal Disease Control Program.

Because of the increasing incidence of gon-

orrhea and the frequency of asymptomatic infection in females, bacteriological culturing is encouraged for females ages 15 to 45, who are undergoing gynecological examination. Unless bacteriological screening is performed to detect asymptomatic disease in the female, many cases of gonorrhea will remain undiagnosed.

Recently a short questionnaire was sent to physicians asking whether they plan to use the bacteriologic culture service described here. More than one-half of the questionnaires were returned and a summary of them indicates a probable need to culture approximately 140,000 females during the next 12 month period.

CHLORAMPHENICOL-RESISTANT SALMONELLA TYPHI—MEXICO

In May 1972, Mexican authorities announced a widespread outbreak of typhoid fever in the State of Hidalgo and the Federal District of Mexico. A high proportion of isolates of Salmonella typhi recovered from patients in this outbreak were resistant to chloramphenicol in vitro and in vivo. In 1972, Mexico reported 6,342 cases of typhoid, an increase of 104% from 1971. There has been evidence of further outbreak in other parts of Mexico, including Acapulco, but this reported incidence has apparently declined in recent weeks.

The strain of S. typhi responsible for the epidemic has had a characteristic degraded Vi(A) phage type. Although some isolates of S. typhi with this phage type tested at CDC have been sensitive to chloramphenicol, the overwhelming majority are resistant to this drug. Multiple-drug resistance in this strain is mediated by an episome.

Intensive surveillance of cases of typhoid fever caused by the chloramphenicol-resistant strain has revealed 49 cases in the United States since the beginning of the Mexican epidemic. The infection was contracted in Mexico by all but 3 of 44 patients on whom a travel history was available. This represents an incidence no greater than 2 per 100,000 in the conservative estimate of over 2 million persons who traveled to Mexico by land, air and sea from the United States in the past 12 months. There have been no fatalities in cases reported in U. S. citizens.

A total of 302 U. S. cases of typhoid fever have been reported to CDC in the first 18 weeks of 1973; 205 of these were in Florida, where a large outbreak due to a chloramphenicol-sensitive strain occurred in February and March (MMWR, Vol. 22, Nos. 9, 10, 13, and 14). The 97 cases in the other 49 states and the District of Columbia represent an increase of 11 over the average for the preceding five years.

The epidemic of chloramphenicol-resistant typhoid fever in Mexico serves to re-emphasize advice for U. S. residents planning travel to areas where typhoid is prevalent. The traveler should use discrimination in his choice of food and beverages. The safest foods are those that are cooked and served hot. Salads, raw vegetables and unpeeled fruits should be avoided. Commercially bottled or canned mineral water and bottled or canned beverages are generally safe. Ideally, tap water should not be consumed unless first boiled or treated with chemical purifiers such as Globaline, Halazone or hypochlorite-containing bleach. Water which is uncomfortably hot to touch may also be safe for drinking after it has cooled. Ice should be avoided. Eating places with substandard hygienic conditions should not be patronized. These precautions are equally applicable to the prevention of other infections, such as non-typhoid salmonellosis, shigellosis, amebiasis, and infectious hepatitis, to which international travelers may be exposed.

Typhoid vaccine can provide additional protection against contracting typhoid fever. However, the vaccine is only partially effective and is in no way a substitute for careful attention in the selection of safe food and drink. Prophylactic antimicrobial drugs are of questionable value and may even be harmful.

When the diagnosis of typhoid fever is sus-

Taken from May 5, 1973 "Morbidity and Mortality Weekly Report."

pected in a patient, a careful history should be taken concerning possible travel to Mexico or other highly endemic areas. S. typhi isolates should be routinely tested for sensitivity to chloramphenicol and ampicillin. Illness due to chloramphenicol-resistant strains should be treated with parenteral ampicillin, which may also be used as the initial drug in patients with a history of travel to Mexico while antibiotic susceptibility tests are pending.

CDC has confirmed resistance to both chloramphenicol and ampicillin in a small proportion of isolates obtained from Mexican patients. No case of typhoid due to the strain resistant to both drugs has been reported to CDC from the United States.

Morbidity Report for May, 1973

Disease	May 1973	1973 to Date	1972 to Date	Most May Cases Reported From These Counties
Adenovirus 7 infection	1	1		Polk
Amebiasis	3	7	11	Dallas
Chickenpox	1235	10255	5112	Scattered
Conjunctivitis	100	756	425	Scattered
Enterobiasis	1	1		Scott
Enteropathic E. coli infection	1	2		Dubuque
Erythema infectiosum	177	1297		Scattered
Gastrointestinal viral infection	333	5134	3755	Scattered
Giardiasis	2	2		Dubuque, Pottawattamie
Guillian-Barré syndrome	1	3		Marion
Hand, foot and mouth	1	1		Johnson
Hepatitis, infectious	13	116	101	Scattered
Hepatitis, serum	2	21	19	Polk
Herpes simplex	11	28		Johnson, Monona, Woodbury
Impetigo	25	198	203	Scattered
Infectious mononucleosis	67	426	398	Scattered
Influenza-like illness	451	11246		Scattered
Meningitis, aseptic	1	2		Cerro Gordo
Meningitis, H. influenza	1	4	1	Wright
Meningitis, pneumococcus	1	2		Pottawattamie
Meningo-encephalitis	1	3		Webster
Mumps	399	2784	4652	Scattered
Pediculosis	9	89		Dubuque, Johnson, Linn, Marshall
Pinworms	1	2		Linn
Pneumonia	89	592	343	Scattered
Rabies in animals	24	110	93	Scattered
Rheumatic fever	3	14	17	Carroll, Delaware, Scott
Ringworm, body	6	67	42	Black Hawk, Pottawattamie
Ringworm, scalp	3	3		Osceola, Warren
Roseola	2	3	5	Dubuque, Humboldt
Rubella	15	166	299	Scattered
Rubeola	53	237	368	Scattered
Salmonellosis	11	42	33	Scattered
Shigelosis	15	112	83	Scattered
Streptococcal infection	528	4044	3363	Scattered
Tuberculosis, active	5	44	41	Scattered
Tuberculosis, inactive	3	12		Scattered
Venereal disease gonorrhea	462	2346	2112	Scattered
syphilis	29	150	165	Scattered

1974 SCIENTIFIC SESSION IN IOWA CITY

The dates of April, 18, 19 and 20 have been tentatively reserved for the 1974 Scientific Program of the Iowa Medical Society. IMS President Rubin Flocks, M.D., has extended an invitation on behalf of the College of Medicine to hold the meeting in Iowa City on these dates.

R. D. Whinery, M.D., Iowa City, will serve as chairman of the 1974 IMS Program Committee. Serving with him will be R. M. Caplan, M.D., Iowa City, L. J. Gugle, M.D., Ottumwa, C. P. Hawkins, M.D., Clarion, J. F. Murphy, M.D., Boone, H. J. Smith, M.D., Des Moines, J. E. Tyrrell, M.D., Manchester, and S. E. Ziffren, M.D., Iowa City.

OFFICIAL PROCEEDINGS

1973 HOUSE OF DELEGATES
APRIL 28-30, 1973
DES MOINES, IOWA

(Alphabetical Index—Page 369)

SATURDAY SESSION, APRIL 28, 1973

The House of Delegates of the Iowa Medical Society was called to order by the Speaker, L. D. Caraway, M.D., of Amana, at 2:00 p.m., Saturday, April 28. The House approved the taking of attendance by signed registration cards. There were 98 delegates, 12 voting alternates and 16 ex-officio members present.

COUNTY	DELEGATE
Allamakee	C. R. Rominger
	(Alternate)
Appanoose	A. S. Owca
Black Hawk	G. R. Clark
	C. D. Ellyson
	R. S. Gerard
	A. M. Dolan
	(Alternate)
Boone	E. E. Linder
Bremer	V. H. Carstensen
Buchanan	L. J. Flage
Calhoun	R. P. Ferguson
Carroll	J. E. McGill
Cerro Gordo	W. V. Wulfekuhler
	H. W. Alcorn
	G. H. West, Jr.
Cherokee	G. E. Michel
Clay	Mary L. Gannon
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Crawford	R. A. Huber
	(Alternate)
Dallas-Guthrie	E. E. Lister
	W. A. Seidler, Jr.
Davis	H. M. Perry
Decatur-Ringgold	E. E. Gamet
	D. E. Mitchell
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	L. F. Wallace
Dickinson	D. F. Rodawig, Jr.
Dubuque	J. A. Pearson
	J. W. White
Emmet	R. J. Dawson
Fayette	D. J. Ottilie
Franklin	R. E. Munns
Fremont	F. M. Ashler
Grundy	D. R. Kruschwitz
Hamilton	G. A. Paschal
Hardin	T. C. Graham
Harrison	J. W. Barnes
Humboldt	J. H. Coddington
Iowa	B. M. Byram
Jackson	J. A. Broman
	(Alternate)
Johnson	R. C. Brown
	S. W. Greenwald
	C. E. Hartford
	L. H. Jacques
	K. J. Judiesch
	C. E. Radcliffe
	P. M. Seebohm
	C. A. Skaugstad
	R. D. Whinery
Jones	A. P. Randolph
	(Alternate)
Keokuk	Opas Jutabha
Kossuth	M. G. Bourne
	(Alternate)
Lee	G. C. McGinnis
	W. B. Kasiske
Linn	C. R. Aschoff
	R. M. Chapman
	R. W. Conkling
	R. A. Sautter
	R. M. Quetsch
	(Alternate)
Mahaska	S. A. Smith
Marion	P. C. Todd
Marshall	W. T. Shultz
	L. O. Goodman
Mitchell	R. G. Boeke
Monona	J. L. Garred
Montgomery	Oscar Alden
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Page	K. J. Gee
Plymouth	J. P. Trotzig
Pocahontas	James Gannon
Polk	John Hess, Jr.
	J. G. Thomsen
	J. I. Hostetter
	N. W. Irving, Jr.
	J. E. Kelsey
	R. K. Bunten
	D. C. Young
	A. N. Smith
	D. O. Newland
	J. W. Green, Jr.
	N. K. Rinderknecht
	Lester Beachy
	(Alternate)
	C. H. Denser, Jr.
	(Alternate)
Pottawattamie-Mills	Hormoz Rassekh
	A. L. Sciortino
	R. K. Fryzek
	J. W. Mathiasen
	(Alternate)
Poweshiek	H. R. Light
Scott	D. A. Bovenmyer
	A. W. Boone
	J. F. Collins
	J. C. Donahue
Shelby	J. H. Spearing
Sioux	E. B. Grossmann, Jr.
Story	W. R. Bliss
	Charles Jons
	(Alternate)
Tama	A. J. Havlik
Union-Taylor	R. H. Kuhl
Wapello	L. E. Coppoc
	R. P. Meyers
Wayne	K. A. Garber
Webster	L. J. O'Brien
Winneshiek	C. E. Larson
Woodbury	C. T. Helseth
	P. J. Monnig
	(Alternate)
Wright	C. P. Hawkins

LIAISON DELEGATES

S. P. Leinbach C. W. Seibert

EX-OFFICIO MEMBERS OF THE HOUSE

K E. Lister	J. M. Rhodes
R. H. Flocks	L. D. Caraway
Erling Larson, Jr.	L. W. Swanson
V. L. Schlaser	H. J. Smith
T. A. Burcham	H. L. Skinner
R. L. Wicks	J. W. Eckstein
J. F. Paulson	J. H. Sunderbruch
J. F. Bishop	R. F. Birge

V. L. Schlaser, M.D., Secretary of the Society, moved that the minutes of the April 26, 1972 session of the House of Delegates be approved as published in the July, 1972 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The motion passed.

Dr. Caraway introduced the individuals at the head table and welcomed 23 new voting Delegates to the House. He directed attention to the "Working Procedures for House of Delegates," in the Delegates' packets; announced reference committee appointees and stressed the importance of reference committees.

Reports in the 1973 HANDBOOK FOR THE HOUSE OF DELEGATES were approved as published, except for the Report of the Committee on House of Delegates Apportionment (pages 59 through 67). Dr. Schlaser explained that adoption of the reports in the Handbook, excepting the previously noted report, did not constitute adoption of any new policy; the reports were noted as being information only. Dr. Caraway referred the Report of the Committee on House of Delegates Apportionment (pages 59-67) to the Reference Committee on Articles of Incorporation and By-Laws. Next, Dr. Caraway introduced L. Neil Sutherland, Assistant Director of Public Affairs Division of AMA, Gary Fetgater, Assistant Director, Department of Planning and Development of AMA, and Raymond T. Holden, M.D., AMA Trustee. (Dr. Holden's remarks appear on page 295 of this issue of the JOURNAL.)

(Following are the reports previously published in the 1973 HANDBOOK FOR THE HOUSE OF DELEGATES.)

Reports of Officers

FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings. Assistance is also provided to the district councilors in organizing and improving the component societies, and in extending the usefulness of the IMS.

COMMUNICATIONS

The Iowa Medical Society uses various methods to maintain contact with the membership and to apprise Iowa physicians (1) of the many projects and programs undertaken by the Society, and (2) of its position on the numerous issues which confront medicine. Following is a listing of communications published and/or distributed through the Society to inform the membership of what is occurring in organized medicine:

1. **IMS JOURNAL**—to all members; subscribers; clinical departments at The University of Iowa College of Medicine as a reference for residents, interns and medical students; also, exchange copies with other medical journals.

2. **IMS NEWS BULLETIN**—to all members, plus a selected group of allied health representatives. Bulletins reporting on IMS and AMA annual meetings are sent to all medical students at The University of Iowa College of Medicine.

3. **LEGISLATIVE BULLETIN**—to L.C.M.'s, Legislative Committee members, Executive Council, IMPAC Board of Directors, county society presidents, various allied health personnel, and to all IMS members when appropriate.

4. **IMS REPORT**—to all state and county medical society officers; to all medical students at The University of Iowa College of Medicine; to all of the previous year's graduates who are interning in various hospitals throughout the country.

5. **IN THE PUBLIC INTEREST**—reprints to all members of the Iowa Press and Iowa Daily Press Associations; all members of the Iowa General Assembly; members of the IMS Woman's Auxiliary.

6. **WOMAN'S AUXILIARY NEWS**—to all members of the IMS Woman's Auxiliary and officers of the Society.

7. **AMERICAN MEDICAL NEWS**—to all members of the Iowa General Assembly.

8. **AMA EXECUTIVE VICE PRESIDENT'S LETTER**—to all members of the Executive Council.

HOUSE OF DELEGATES AND ANNUAL SCIENTIFIC PROGRAM

The proceedings of the 1972 sessions of the House of Delegates were published in the July, 1972 issue of the IMS JOURNAL. The necessary administrative procedures have occurred to implement the directives of the delegates.

Consistent with an action of the 1972 House of Delegates calling for a separation of business and scientific meetings, the annual scientific program will be in Nassau, The Bahamas, March 29-April 2, and the annual meeting of the House of Delegates will be in Des Moines April 28-30. A regular meeting of the House is anticipated in the fall as provided for in the amended Articles of Incorporation and By-Laws.

The March issue of the IMS JOURNAL contains a summary program for the scientific session. It has been approved for 11½ hours of elective credit by the American Academy of Family Physicians. A report on this educational and travel venture will be presented to the House in April.

IMS staff has assisted the District Councilors in organizing their caucuses in preparation for the Annual Meeting and in preparing for the meeting of the Nominating Committee.

EXECUTIVE COUNCIL

The fourth regularly scheduled meeting of the Executive Council will occur April 12 at IMS Headquarters. The Council is the interim policy-making body which meets every three months between sessions of the House of Delegates to act on important issues and problems.

JUDICIAL COUNCIL

The Judicial Council also meets quarterly between sessions of the House. Members of the Judicial Council and Board of Trustees meet for dinner the evening preceding Executive Council sessions; following this, the two bodies conduct their business meetings separately. At the joint dinner, topics of general interest are discussed.

The principal responsibilities of the Judicial Council are (1) to approve applications for IMS membership; (2) to consider various questions regarding membership or ethics; and (3) if necessary, to discipline members of the Society.

A report from the Judicial Council appears elsewhere in the Handbook.

BOARD OF TRUSTEES

A report from the Board of Trustees appears elsewhere in the Handbook. However, it is appropriate to mention here the Board meets monthly to carry out the business affairs of the Society; it meets further in special session when necessary. There is almost daily communication between IMS staff members and the Chairman of the Board and/or President of the Society.

COMMITTEES

Fifty-three standing and special committees were appointed by the President at the beginning of his term. Over 85 official meetings have been held since the House of Delegates adjourned its final session last April, and others are scheduled prior to the opening session of the House in April, 1973.

In addition to formal committee sessions, there are also hundreds of informal contacts between committee members and staff via telephone conferences and personal visits.

The Society has also been represented on councils and committees of other state and voluntary agencies, e.g., the Health Planning Council of Iowa, the Iowa Regional Advisory Group, the Advisory Council to the Office for Comprehensive Health Planning, Advisory Committee on Emergency Medical Services, Advisory Committee on Physicians' Assistants Program, the Iowa Health Council, the Inter-Agency Smoking Committee, Steering Committee on Family Practice Residencies, etc.

NATIONAL, REGIONAL AND STATE CONFERENCES

The Trustees have been selective in authorizing IMS representation at national, regional and state conferences. The Trustees believe that both gathering and exchanging information on medical programs and issues are important and beneficial to the Society. Following is a partial listing of the major conferences at which the IMS was represented this past year: American Medical Association—Annual and Clinical Meetings; Congress on Medical Education; Conference on Quackery; Conference on Physicians & Schools; Rural Health Conference; Conference on Medicine and Religion; Communications Institute; Medical Ethics Conference; North Central Medical Conference; AMPAC; Blue Shield Annual Program Conference; Blue Shield Board of Directors Meetings; State Meetings of Allied and Voluntary Health Groups; AMA National Leadership Conference; Quality of Life Conference; Practice Management Program.

IOWA REPRESENTATION AT THE NATIONAL LEVEL

The Society maintains close liaison with the AMA at both the officer and staff level. Several IMS members serve on AMA Councils and Committees, including the following: D. F. Ward, M.D., Dubuque, Council on Legislative Activities; C. H. Denser, Jr., M.D., Des Moines, Committee on Quackery; H. J. Smith, M.D., Des Moines, Committee on Government Medical Services; W. C. Keettel, M.D., Iowa City, Residency Review Committee—Obstetrics and Gynecology; B. F. McCabe, M.D., Iowa City, Residency Review Committee—Otolaryngology and Archives of Otolaryngology; R. H. Flocks, M.D., Iowa City, Residency Review Committee—Urology and Interspecialty Committee; and D. B. Kettelkamp, M.D., Iowa City, Archives of Surgery.

Donald L. Taylor, IMS Executive Vice President, a past-president of the American Association of Medical Society Executives, and three other IMS staff members, are active in the AAMSE organization. Mr. Taylor also serves on a special Advisory Committee to the AMA Executive Vice President; is a member of the American Association of Foundations for Medical Care (AAFMC) Task Force to Department of HEW on Professional Standards Review Organizations (PSRO); is a member, AMA Ad Hoc Committee on Federal-State Legislation; and is a member of the Board of Directors of the Professional Convention Management Association.

IMS FIELD SERVICE

Mr. Eldon Huston, Assistant Executive Vice President, directs the joint IMS/Blue Shield field service program. The six field representatives maintain direct personal contact with individual physicians throughout the state and provide a valuable service to them, as well as to organized medicine and to Blue Shield. The representatives operate in designated regions, and according to comments received from physicians, they function effectively and provide valuable information and assistance.

Mr. Huston's responsibility in this area of activity was recently broadened and he will now be in charge of all provider services, including both hospital and physician relations.

WOMAN'S AUXILIARY

The facilities and services at the IMS Headquarters are made available to the Woman's Auxiliary. Mrs. Sandy Nichols was designated the Auxiliary's staff secretary on the retirement of Mrs. Hazel Lammey, who served in this capacity for approximately 18 years. Assistance is provided to the Auxiliary in arranging its Annual Meeting and Board of Directors sessions, in preparing its annual reports, in maintaining its membership records, and in preparing and distributing the WOMAN'S AUXILIARY NEWS. The Auxiliary annually sponsors a continental breakfast at the IMS Headquar-

ters office for the wives of Iowa's legislators and executive officers.

IMS MEMBERSHIP

Iowa Medical Society membership for 1972 totaled 2,297. Of this number, 142 held active dues-exempt membership (116 life members, 23 residents, and 3 members in military service), and 71 associate members were exempt from the payment of dues. There were 51 counties (in 48 single or two-county societies) in which 100 per cent of the county society members held membership in the IMS. Physicians ineligible for membership numbered 65, and there were 219 eligible non-members in Iowa. The number of retired or not-in-practice physicians was 52. The percentage of eligible physicians who held IMS memberships was 91 for the year.

AMA MEMBERSHIP

The members of the Iowa Medical Society who were active members of the American Medical Association in 1972 numbered 2,107. (This number includes active members who were dues-exempt because of life membership or military service.) In addition, 71 held associate memberships.

The 2,107 AMA memberships in 1972 entitled Iowa to three AMA delegates. In 1972 the Iowa AMA membership was 95 per cent of the total Iowa Medical Society membership.

V. L. SCHLASER, M.D., *Secretary*

COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP IN IMS IN 1972

Adair	Delaware	Madison
Adams	Dickinson	Marshall
Appanoose	Emmet	Mitchell
Audubon	Franklin	Monona
Boone	Fremont	Monroe
Buena Vista	Grundy	Montgomery
Butler	Hancock-	O'Brien
Cass	Winnebago	Pocahontas
Cedar	Hardin	Shelby
Cerro Gordo	Howard	Sioux
Chickasaw	Humboldt	Tama
Clarke	Ida	Union-Taylor
Clay	Jackson	Van Buren
Crawford	Jefferson	Washington
Davis	Keokuk	Wayne
Decatur-Ringgold	Kossuth	Wright
	Lucas	

1972 IMS MEMBERSHIP RECORD

County	Active Members	Associate Members	Eligible Non-Members	Ineligible Non-Members	Not in Practice or Retired	Percentage
Adair	1	..	..	..	..	100
Adams	2	..	..	..	..	100
Allamakee	8	..	1	..	..	89
Appanoose	8	1	..	..	1	100
Audubon	3	..	..	..	..	100
Benton	7	..	2	..	..	78
Black Hawk	117	5	5	..	3	96
Boone	16	1	..	..	..	100
Bremer	13	1	1	..	1	93
Buchanan	15	..	3	5	1	83
Buena Vista	10	..	..	..	..	100
Butler	6	..	..	..	..	100
Calhoun	7	..	3	..	1	70
Carroll	21	1	3	..	..	88
Cass	12	..	..	..	..	100
Cedar	5	..	..	..	1	100
Cerro Gordo	73	2	..	..	1	100
Cherokee	18	..	7	..	1	72
Chickasaw	6	..	..	..	..	100
Clarke	6	..	..	..	..	100
Clay	8	..	..	..	..	100
Clayton	5	1	3	..	1	67
Clinton	28	2	14	1	1	68
Crawford	8	..	..	..	..	100
Dallas-Guthrie	17	1	4	3	..	82
Davis	14	..	..	..	..	100
Decatur-Ringgold	7	..	..	..	..	100
Delaware	7	..	..	..	..	100
Des Moines-Louisa	45	1	7	..	1	87
Dickinson	8	1	..	..	..	100
Dubuque	52	1	30	..	..	64
Emmet	13	..	..	..	..	100
Fayette	11	2	4	..	..	77
Floyd	13	..	3	..	..	81
Franklin	4	..	..	1	..	100
Fremont	4	..	..	..	..	100
Greene	7	..	1	..	..	88
Grundy	6	..	..	..	..	100
Hamilton	5	2	1	..	..	88
Hancock-Winnebago	12	..	..	1	1	100
Hardin	9	1	..	..	..	100
Harrison	8	..	1	..	..	89
Henry	15	..	1	3	..	94
Howard	6	1	..	..	..	100
Humboldt	4	2	..	..	..	100
Ida	2	..	..	..	1	100
Iowa	9	..	1	..	..	90
Jackson	11	..	..	..	..	100
Jasper	17	..	2	..	1	89
Jefferson	12	..	..	..	..	100
Johnson	259	..	26	20	2	91
Jones	9	..	2	..	..	82
Keokuk	5	2	..	..	..	100
Kossuth	10	1	..	..	..	100
Lee	39	2	1	2	..	98
Linn	129	10	24	..	2	85
Lucas	3	..	..	..	..	100
Lyon	4	1	1	..	..	83
Madison	3	..	..	..	..	100
Mahaska	18	..	2	..	..	90
Marion	13	..	4	10	3	77
Marshall	44	..	..	..	2	100
Mitchell	11	1	..	..	..	100
Monona	7	..	..	..	1	100
Monroe	3	..	..	..	..	100
Montgomery	11	..	..	..	..	100
Muscatine	13	..	2	1	..	88
O'Brien	12	..	..	..	..	100
Osceola	..	..	4	..	..	..
Page	18	..	2	2	1	90
Palo Alto	8	..	1	..	..	89
Plymouth	9	..	1	..	..	90
Pocahontas	6	..	..	..	1	100
Polk	335	15	21	14	2	95
Pottawattamie-Mills	67	1	5	2	4	93
Poweshiek	9	..	2	..	..	82
Sac	..	..	6	..	..	..
Scott	112	1	5	..	3	96
Shelby	10	..	..	..	1	100
Sioux	13	..	..	..	..	100
Story	60	3	4	..	1	94
Tama	8	..	..	..	..	100
Union-Taylor	15	..	..	..	..	100
Van Buren	2	..	..	..	..	100
Wapello	39	1	2	..	2	95
Warren amalgamated with Polk						
Washington	9	..	..	..	2	100
Wayne	2	..	..	..	1	100
Webster	52	..	1	..	3	98
Winneshiek	12	1	1	..	..	93
Woodbury	107	5	4	..	5	97
Worth	3	..	1	..	..	75
Wright	16	..	..	..	..	100
TOTALS	2226	71	219	65	52	91

REPORT OF THE TREASURER

The following financial statements reflect the fiscal status of the Iowa Medical Society as of December 31, 1972.

The 1971 expenses exceeded income by $33,556.29.

IOWA MEDICAL SOCIETY

Balance Sheet—December 31, 1972

ASSETS

Current Assets:		
IMS Checking Accounts		$ 14,829.34
IMS Savings Account		552.81
Accounts Receivable		2,400.00
Note Receivable (Baldridge-Beye)		750.00
Pension and Disability Insurance—Due from Employees		294.41
Prepaid Expenses		300.00
Investments		48,758.92
Short Term Investments		80,000.00
TOTAL CURRENT ASSETS		$147,885.48
Fixed Assets:		
Land		$ 74,216.96
Building	$308,264.76	
Office Furniture & Equipment	38,334.81	
Less: Reserve for Depreciation	-203,565.00	$143,034.57
Net Fixed Assets		$217,251.53
TOTAL ASSETS		$365,137.01

LIABILITIES AND NET WORTH

Liabilities:		
Accounts Payable		$ 6,321.31
Accrued Personal & Property Tax		14,000.00
Deferred Compensation		48,758.92
Due to Employees		1,232.67
Deferred Income		190,000.00
Baldridge-Beye Memorial Fund: Note 12-31-72		750.00
TOTAL LIABILITIES		$261,062.90
Net Worth:		
Balance 1-1-72	$137,630.40	
Less: Net Excess of Expenses over Income	- 33,556.29	
Balance Net Worth		$104,074.11
TOTAL LIABILITIES AND NET WORTH		$365,137.01

BOARD OF TRUSTEES REPORT

As has been its custom, the Board of Trustees will present a detailed and up-to-date accounting of the Society's finances and activities to the House of Delegates in a special Supplemental Report. It will include a resume of the budget for 1973 and information regarding the IMS dues structure.

The Board of Trustees meets monthly in order to take action on and oversee the numerous and varied projects of the Iowa Medical Society.

RALPH L. WICKS, M.D., *Chairman*

IOWA MEDICAL SOCIETY
STATEMENT OF INCOME AND EXPENSES

For the Year Ended December 31, 1972

Income for the Year 1972:	
Dues—State Society	$308,532.00
Interest on Investments	1,556.83
Miscellaneous	642.68
AMA Collection Commission	2,135.45
TOTAL INCOME	$312,866.96
Expenses for the Year 1972:	
Annual Session (Net)	$ 6,804.19
Council Expense	2,817.85
County Society Services	3,618.64
Depreciation—Bldg. & Equipment	36,000.00
Dues and Subscriptions	2,180.50
Employee Pension, Disability & Health	15,444.38
Field Service	15,104.17
General Administrative Expense	2,967.74
Insurance	2,944.82
Interest Expense	568.61
Journal (Net)	14,896.98
Legal Expense	6,370.00
Lights, Gas & Water	6,137.63
Loss on Sale of Stock (Net)	309.31
Office Stationery & Supplies	6,203.16
Postage	7,566.99
Repairs & Maintenance	7,995.55
Salaries	116,170.86
Service Contracts—Machines	1,440.33
Taxes:	
Personal & Property	12,885.82
Social Security/Unemployment	6,157.69
Telephone & Telegraph	8,499.50
Travel—Officers	14,163.23
Travel—Salaried Employees	13,469.61
Trustee Expense	4,587.21
Woman's Auxiliary	5,143.10
Committee Expense	25,975.38
TOTAL EXPENSE	$346,423.25
Net Excess of Expenses over Income for 1972	$ 33,556.29

THOMAS A. BURCHAM, M.D., *Treasurer*

REPORT OF THE JUDICIAL COUNCIL

The individual members of the Judicial Council have continued to function as "peace makers" within their respective districts. The 12 Councilors have been requested to resolve numerous questions and misunderstandings which have arisen in the medical community. The Judicial Council has met quarterly to act on membership (active, life, associate) and other matters which relate to physician conduct. Fortunately most of the matters brought to the Council can be resolved promptly through the application of established and well defined ethical standards.

The Judicial Council has joined with the Board of Trustees this year to formulate "Guidelines for the Nominating Committee" to aid that Committee in selecting physicians to stand for election to IMS offices. These new guidelines are now being implemented.

The Judicial Council continues to be concerned over the steady decline in number of physicians who are active members of the Iowa Medical Society. The Coun-

cil is acutely aware that only through unity within the profession can medicine achieve its goals. The Iowa Medical Society is the appropriate voice for Iowa physicians on the scientific and socio-economic aspects of medical care.

The Judicial Council has followed with interest the deliberations of the special Committee on House Apportionment, particularly those recommendations which relate to "redistricting." Two members of the Council have served on this special committee. The Judicial Council believes every physician should study the recommendations of the Committee on House Apportionment carefully to assure the proper decisions will result and provide the Society with the most effective policy-making body to meet the challenging years ahead.

E. E. GAMET, M.D., *Chairman*

Reports of Standing Committees

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

The 1972 House of Delegates instructed the Committee to prepare amendments to implement a minimum attendance requirement for members of the Judicial Council. In doing so the Committee was asked to consider provisions wherein the represented county medical societies would be notified if and when their councilor attended less than 60% of the Judicial Council meetings on an unexcused basis. And further, that when at the end of any one year, a councilor attended fewer than 60% of the meetings, his councilor seat would be declared vacant.

The 1972 House of Delegates also adopted an amendment introduced from the floor which provides for three alternate delegates to the AMA House of Delegates in lieu of the existing provision for one alternate delegate. This change requires amendment of other sections of the Articles of Incorporation and By-Laws. The Standing Committee is considering these changes and will submit appropriate implementing language for consideration by the 1973 House of Delegates.

The Committee is aware the Committee on House Apportionment will submit several recommendations which if adopted will require amendments to the Articles of Incorporation and By-Laws. Since the Committee on House Apportionment is suggesting final consideration of its recommendations be delayed until a fall meeting of the House, this Committee has not considered language to implement the recommendations of the Committee on House Apportionment. The Standing Committee will submit a supplemental report with formal language to (1) set minimum attendance requirements for the Judicial Council, and (2) provide for three alternate delegates to the AMA House of Delegates.

JAMES F. BISHOP, M.D., *Chairman*

GRIEVANCE COMMITTEE

The Grievance Committee met at irregular intervals during the past year. Eleven complaints were received this year, the fewest number for a number of years. The complaints were also unique, in that all involved patient complaints against physicians. In the past, several complaints involved a physician's grievance against another physician. The question of fees was not involved in most complaints, but the patient in most cases felt abused because of a lack of communication, or inadequate communication by the physician. The problem of failure of communication as a common cause of grievance has been emphasized before in reports by this Committee.

S. E. ZIFFREN, M.D., *Chairman*

COMMITTEE ON HEALTH EDUCATION

The Chairman of the Health Education Committee has been appointed by the American Medical Association to serve as a representative on the AMA and National Education Association Joint Committee on Health Problems in Education. His term extends from 1973 through 1977. This AMA-NEA committee is a coordinating and liaison body which affords medicine and education an opportunity to confer on matters related to health of children and youth. It reviews problems with medical and educational implications, and its pronouncements and resolutions have been used effectively in guiding school health programs.

WOI Radio, Ames, Iowa, continues to broadcast weekly programs on various health topics. Physician participants for these programs are secured by the IMS, and the overall effort is coordinated by the Health Education Committee. Betty Lou Varnum of WOI has made special trips to Des Moines and Iowa City to tape programs for the series. Iowa physicians have also traveled to Ames to participate in the program. The Society also assists WOI-TV in the development of special television programs on health subjects.

The Society has responded positively to many requests for speakers and films which have been received from both lay and professional groups during the past year.

Members of the Society are commended for their willingness to devote their time and talent to impart information on important health subjects via radio, television and in personal speaking appearances. This is an excellent public relations activity which enhances the physician's image.

The Committee stands ready to assist any county medical society in the development of special health education programs for radio or television. For instance, last May a successful television program on human sexuality was sponsored and arranged by the Woman's Auxiliary to the Black Hawk County Medical Society; this project involved the Committee chairman and others.

C. D. ELLYSON, M.D., *Chairman*

NECROLOGY COMMITTEE

The following members of the Iowa Medical Society died during 1972:

	Age
William E. Ash, Council Bluffs	82
J. Norman Bickert, Aurora, Colorado	85
Arthur L. Blome, Ottumwa	64
Louis L. Bowie, Zearing	93
William E. Bullock, Lake Park	101
Thomas A. Burke, Mason City	87
John G. Clapsaddle, Algona	87
Charles L. Closson, Walker	88
Arthur E. Crew, Cedar Rapids	97
Glenn M. Dalbey, Traer	55
John W. Dulin, Iowa City	66
Robert L. Feightner, Fort Madison	78
Willis M. Fowler, Iowa City	72

James F. Gerken, Waterloo 74
John H. Henkin, Sioux City 81
J. Donald Hennessy, Council Bluffs 64
Clarence A. Johnson, Coon Rapids 74
Gerald F. Keohen, Dubuque 57
Elmer H. Littig, Mechanicsville 67
Harold J. McCoy, Des Moines 81
Charles W. Maplethorpe, Toledo 86
Frank W. Meyers, Dubuque 98
Donald F. Miller, Williamsburg 65
Evan A. Peterson, Burlington 75
John C. Peterson, Hartley 57
Anthony C. Pfohl, Dubuque 72
Samuel D. Poore, Villisca 50
Ivan Powers, Waterloo 76
Andrew W. Puntenney, Des Moines 60
William M. Rohrbacher, Iowa City 84
William G. Rowley, Sioux City 91
Leander H. Schafer, DeWitt 71
George J. Severson, Slater 91
Raleigh R. Snyder, Des Moines 87
Jacob J. Stegman, Marshalltown 68
Ernest J. Voigt, Mediapolis 79
Martin M. C. Wang, Clinton 54
Clyde F. Watts, Marengo 82

COMMITTEE ON LEGISLATION

Several developments on the Congressional scene are worthy of note:

HR 1 (Social Security Amendments of 1972) has been passed and signed into law. Among its many provisions is establishment of Professional Standards Review Organizations. The Department of Health, Education and Welfare, which is responsible for administration of the Act, has indicated that state and local medical societies will have first opportunity to designate PSRO's for their areas. In response to this challenge, the IMS Executive Council has authorized the Iowa Foundation for Medical Care to seek designation as the PSRO for Iowa.

HMO's—no federal action has been taken on HMO legislation. However, the President still considers HMO legislation a priority matter and passage of some HMO bill appears likely in this session of Congress. In addition to the President's plan, Senator Edward Kennedy is advocating adoption of his plan.

National Health Insurance—at this time, the AMA, the American Hospital Association, the President and Senator Kennedy have all introduced legislation calling for the adoption of some form of national health insurance. At the moment, the strength of the several plans is uncertain; the AMA Medicredit bill has over 150 sponsors. Most experts on the Washington scene believe formal consideration of national health insurance will be delayed until the second session of the 93rd Congress.

IMS representatives are now planning the annual trip to Washington, D. C. for early in March. This annual meeting with the Iowa congressional delegation has proved to be a worthwhile method of contacting Iowa's lawmakers at the federal level.

The 1973 Iowa General Assembly has a new look with two-thirds of the members of the House having no past legislative experience. All things point to a long session, adjourning in late May or early June. Biweekly Legislative Bulletins are sent to legislative contact men, key IMS officers and committee members to keep them current on health legislation. This enables physicians to visit informally at the local level with their legislators about health legislation.

J. H. KELLEY, M.D., *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Committee on Medical Education and Hospitals, in cooperation with the Office for Continuing Medical Education, University of Iowa College of Medicine, is making a random sample survey of 150 members of the Iowa Medical Society in an effort to obtain information about physician activities in continuing medical education, and physician opinion on many important current issues in continuing education. Information from the survey is expected to be useful and valuable to both the IMS and the College of Medicine in the development of CME activities and programs. A summary of the survey results will be presented to the membership.

The IMS Executive Council has approved a Committee recommendation which urges strong Society support for local in-hospital evaluations of medical practice as a facet of continuing medical education. In this connection, it is emphasized that CME courses and conferences should not be de-emphasized; however, the fact that CME is a day-to-day physician activity should be underscored. The Committee believes increasing emphasis should be placed on the educational value of studying, in some organized way, the actual practice procedures in a hospital or office setting. On an in-hospital basis, this could be accomplished by reviewing diagnosis and treatment procedures for specific illnesses, and discussing with the medical staff deviations from what are considered to be acceptable standards of care.

The IMS is cooperating with the College of Medicine (Office for CME) in sponsoring a series of six regional workshops on quality assurance programs in community hospitals, March 3 through May 27. The workshops are designed to prepare physicians and appropriate personnel for their vital roles in assessing and assuring optimal health care in community hospitals. Through small group sessions and faculty presentations, participants will have opportunity to develop descriptions of optimal care, interpret data about care delivered, identify continuing education needs, and plan any necessary educational or administrative changes.

The Society co-sponsored a similar program at Lake Okoboji last summer. This program served as a stimulus for the workshops scheduled this spring.

The Committee has devoted some attention to the utilization of the Problem Oriented Medical Record System. An article entitled "How to Start Using the Problem Oriented Medical Record" was published in the April 1972 issue of the IMS JOURNAL, and an effort will be made to determine the interest of Iowa physicians in attending regional meetings on this concept. The Committee has been apprised that POMR is being implemented by some departments at The University of Iowa, including the Department of Family Practice, thus medical students are being exposed to the approach.

The Committee has obtained informational materials from the AMA on the implementation of a CME accreditation program by a state medical society (i.e., state society approval of specific CME programs sponsored by various institutions and voluntary health organizations within a state, with prior AMA approval of the state society's accreditation program). This appears to be a large undertaking, and the Committee intends to consult further with a representative of the AMA

Department of Medical Education regarding the feasibility of instituting such a program in Iowa. As reported to the House last year, any accreditation program that might be designed for implementation by the IMS will be referred to the Executive Council or House of Delegates for final approval.

The Committee acknowledges the position of the IMS with respect to opposing a mandatory program of continuing medical education for maintaining membership in the state society. However, it also wishes to call attention to the AMA's Physician Recognition Award program, a voluntary program which is designed to recognize and encourage physicians who participate regularly in CME. The Award is granted for a minimum of 150 hours of CME activities earned over a three-year period. There are six categories of CME activities which are creditable for the 1972 Award, i.e.:

I—CME with Accredited Sponsorship, 60 hours (no limit)
II—CME with Non-Accredited Sponsorship, 45 hours (no limit)
III—Medical Teaching, 45 hours (no limit)
IV—Papers, Publications, Books, Exhibits, 40 hours (no limit)
V—Non-Supervised Individual, 45 hours (no limit)
VI—Other

The Chairman of the Committee attended an AMA Conference on Continuing Medical Education in Chicago last October. The major topics included accreditation of CME by state medical societies, requirement of CME participation for state medical society membership, peer review as an educational necessity, and self-assessment as an educational tool.

The Committee wishes to commend Richard Caplan, M.D., Assistant Dean for CME at The University of Iowa College of Medicine, and a member of this Committee, for the excellent articles he prepares for the IMS JOURNAL and which appear regularly under the title "Educationally Speaking."

The Program Committee also deserves a commendation for arranging the outstanding series of lectures and discussions to be presented during the 1973 Scientific Session. The program has been approved for 11½ hours of elective credit by the American Academy of Family Physicians.

Special note should be taken of efforts of the Iowa Medical Society and Iowa Academy of Family Physicians, in consultation with officials of The University of Iowa College of Medicine, to obtain an appropriation (supplemental to the Board of Regents budget) from the 65th Iowa General Assembly to aid in establishing family practice residencies in community based hospitals in Iowa.

Officials of the IAFP developed a specific proposal in this regard and, subsequently, a committee comprised of representatives of the IMS, IAFP, and College of Medicine was appointed to prepare general guidelines to implement community based family practice residency programs in Iowa. Officials of the Academy, the IMS, and the College of Medicine feel if Iowa demonstrates a strong commitment to the development and maintenance of quality family practice residency programs throughout the state, students will be attracted to participate in them and this will enhance the opportunity to recruit more physicians for Iowa communities. The Legislative Committee will undoubtedly report to the House in April on whatever actions are taken by the Iowa Legislature in this regard during its current session.

WILLIAM BLISS, M.D., *Chairman*

COMMITTEE ON MEDICAL SERVICE

The Committee on Medical Service is the parent body for the three subcommittees (Economics of Health Care, Medical Review and Medical Practice in Health Facilities and Homes) whose reports follow these brief comments. Members of the 1973 House of Delegates are urged to read the reports of these several subcommittees.

In 1972-73 the Society has made a sincere effort to respond to the individual inquiries and concerns of member physicians. These inquiries cover a broad subject spectrum, e.g., application of "good faith," "due care," and "hold harmless"; provisions of 1972 SSA amendments; health maintenance organization developments; individual problems with various insurance carriers, etc.

Relations with Blue Cross and Blue Shield, once a more prominent concern of the Committee on Medical Service, will be reported to the 1973 House of Delegates by the Board of Trustees.

J. K. MACGREGOR, M.D., *Chairman*

SUBCOMMITTEE ON ECONOMICS OF HEALTH CARE

The Society's activities in this important area have received attention from the principal officers in 1972-73. The government's economic guidelines for physicians under Phases I, II and III have been closely scrutinized by the Board of Trustees.

Attention is called to the recent action of the American Medical Association in filing a letter with President Richard Nixon calling for physicians to be exempted from Phase III restrictions. Companion to this has been the dispatch of a communication from the Iowa Medical Society to the Iowa congressional delegation requesting relief. Earlier in the year the Society filed a letter of concern with the Committee on Health Services Industry of the Economic Stabilization Program over the 2.5 per cent ceiling on physicians' fee increases.

Note is also made in this brief report of the progress of the Iowa Foundation for Medical Care. Its development of standards and norms to assure quality care in appropriate quantity and at equitable cost deserves commendation. This effort by the medical profession to provide a dynamic review mechanism to measure health care delivery is significant. Its significance is heightened by the forthcoming governmental requirement of professional standards review organizations (PSRO).

The matter of dividing the state for various medical care delivery reasons has been before this Subcommittee previously. It is noted that the Foundation peer review program has been modified to include six district committees in contrast to the previous 12 committee plan. Continuing study in this area is important.

The chairman of the Subcommittee accepted an invitation in 1972 to serve as a Society representative on an Iowa Hospital Association Hospital-Medical Statistical Committee which is concerned with the development of a health services data system.

C. O. ADAMS, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL REVIEW

The Committee's primary objective this year has been to publish the "Standards of Medical Care." The culmination of several months' and many hours' work occurred in July 1972 when copies of the "Standards" were hand delivered to the chiefs of staff of all Iowa hospitals. The Committee is pleased to know many hospital staffs have used the "Standards" as a mechanism to implement and/or refine their utilization review programs. The Committee has received several suggestions for modifications of the "Standards" and these are under formal review.

The Committee has continued to function as a state claims review body and in this capacity has formulated recommendations when requested. The Iowa Medical Society has authorized its peer review activities to be undertaken by the Iowa Foundation for Medical Care. This should reduce substantially the number of cases referred to this Committee.

The Subcommittee on Medical Review has designated three special committees to consult on specific questions this year; this activity has been outside the policy making realm. First, a special study has been made of appropriate criteria for obesity surgery. This subject was considered in depth, and involved a review of the pertinent literature and a personal visit with those physicians most vitally concerned. The findings and recommendations of this special committee study were given to the agencies which requested the medical evaluation. Secondly, a review was made of those surgical procedures which normally do not require the services of a surgical assistant. This consultative service was also completed with recommendations forwarded to the requesting agency. A third special committee assisted the State Department of Social Services in drafting "Guidelines for Nursing Home Patients." This was an attempt to help the Department determine criteria for the various levels of care normally expected in (1) a skilled nursing home, (2) intermediate care facility, and (3) basic nursing home.

The Subcommittee plans at least one additional meeting prior to the 1973 House of Delegates. If specific recommendations are adopted they will be submitted to the House in a supplemental report.

R. S. GERARD, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL PRACTICE IN HEALTH FACILITIES & HOMES

There have been no meetings of the Subcommittee on Medical Practice in Health Facilities and Homes this year. However, there are several matters which may be of interest to the House of Delegates.

In August 1972 rules and regulations governing the operation of non-hospital facilities in Iowa were approved and put into use. These new and extensive regulations are based on a 1971 state law which creates seven classifications of health care facilities: adult foster home, boarding home, custodial home, basic nursing home, intermediate nursing home, skilled nursing home and extended care facility. It is important for IMS members to be aware of the services available in these types of facilities inasmuch as physicians are required under certain governmental programs to specify the level of care a patient should receive.

Reference is made to the report of the Subcommittee on Aging and Chronic Illness where additional information is provided on the new procedures to be followed in providing for state assistance patients residing in intermediate care facilities. Further details on this program which was implemented in January 1973 will be presented in the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Services provided by county public health nurses have increased this year. Eighty-three counties now offer public health nursing on some scale. For the fiscal year concluding June 30, 1972, according to the State Department on Health, 103,000 nursing services were provided to Iowans ill in their homes. This is an increase of approximately 20,000 services over the previous year.

The number of home health agencies certified in Iowa to provide home care services under the Health Insurance Benefits Program has increased in the past year from 45 to 49. Des Moines is one of 15 agencies in the country to have received approval from the National Homemaker-Home Health Care Council.

Two additional items: (1) the Society continues to hold membership in the Iowa Council for Homemaker Services, and (2) the Iowa Nursing Home Association changed its name in 1972 to the Health Facilities Association of Iowa.

J. F. VEVERKA, M.D., *Chairman*

MEDICO-LEGAL COMMITTEE

The Medico-Legal Committee has continued its evaluation of the complex subject of professional medical liability this year. This ongoing evaluation has been undertaken at the behest of the House of Delegates.

In November the Committee conferred for a full day with two experts in the field: James Chastain, Ph.D., Professor of Insurance, Drake University; and Richard Bergen, LL.B., Director, Department of Legal Research, American Medical Association. The services of these men were enlisted to help the Committee examine what it does know, determine what it needs to know additionally, and decide where to obtain this further information.

The advantages of a group, sponsored or endorsed program of professional liability insurance have been examined by the Committee. These include broader product selection, availability of higher limits, specific program tailoring, minimization of coverage duplication, more credible rate determination, improved loss control, etc.

The Committee recognizes some group programs are that in name only and are really only marketing gimmicks. Advantages appear to derive in relation to the extent to which a group is actually a group. The Committee has compared the dispersed insurance agent approach versus the centralized administrator. Both appear to have advantages.

The Committee has been provided a clarification of the rating classifications. It appears some updating of these classes may be in order. Physicians in Class V generally pay five times as much in premium as do Class I physicians. Factors involved in rate making have been explained to the Committee with the additional report that Iowa, by following a prior approval approach, is regarded as having a conservative rate law.

Twelve to 14 companies dominate the professional liability market and compete for the business of approximately 250,000 physicians. Because a high percentage of Iowa physicians are covered by Medical Protective (MP), the structuring of a group program in the state appears to be a formidable task; MP is not interested

in a formal affiliation with a medical society. In contrast, other companies active in the market appear to be working hard to make groups out of covered physicians in an effort to cut expenses and enhance the loss picture.

The Committee has discussed the relatively new program in California where patients admitted to participating hospitals consent in advance to arbitrate any disagreement or claim of malpractice. This program appears to have been successful based on two years' experience. The project is certainly worthy of continued evaluation.

AMA officials have advised the Committee they believe the best way to assure coverage is through a state society sponsored program. There are between 30 and 35 sponsored programs in the country either at the state or metropolitan county level.

In its deliberations to date the Committee has operated with an informational void in terms of knowing the actual temperament of the Society's members as regards malpractice coverage. The expressions of extreme concern from IMS members have been relatively few in number. In view of this, the Committee has surveyed county society officers and members of the House of Delegates recently to secure an impression of the interest and likely participation in a sponsored program. The survey responses are now being received and tabulated. A cursory examination of the replies seems to suggest there is support for a group program. It is anticipated this evaluation will be completed in time for presentation to the House of Delegates in the form of a supplemental report. The findings will be valuable to the Committee in developing further recommendations to the House.

In the meantime, the Committee has encouraged initiation of an education program through periodic publication of material in the JOURNAL OF THE IOWA MEDICAL SOCIETY. Steps to accomplish this have been taken.

Note should be made of the HEW Commission on Medical Malpractice which has completed its deliberations and has compiled approximately 150 recommendations. The early analysis of the recommendations offers a generally negative picture for the medical profession. The Commission has called for modification of malpractice laws at the state level, improvement of the quality of health care, and greater protection for the public. Little in the report appears to address the rising costs of malpractice insurance, the growing number of claims, and the resulting impact on physicians' fees. It is understood that Carl A. Hoffman, M.D., AMA president and a member of the Commission, will submit a minority report to the overall Commission report.

The Medico-Legal Committee will report to the House of Delegates as further information is gathered and recommendations are developed.

C. H. DENSER, JR., M.D., *Chairman*

COMMITTEE ON PUBLIC RELATIONS

Although the Public Relations Committee is functioning on a stand-by basis, it continues to oversee the implementation of many "in the public interest" programs, as well as those designed to enhance public understanding of the physician and the medical profession.

Specific examples of projects undertaken by committees of the Society which have a direct or indirect "P/R" impact include co-sponsorship of a full-day program on sports medicine last March for physicians, coaches and trainers; recent co-sponsorship of a dinner honoring members of the 65th Iowa General Assembly.

Attention is also called to the efforts of IMS officers and committees to establish closer liaison and working relations with both allied health and non-health oriented groups. For instance, the Safe Transportation Committee works on various projects with the Department of Public Safety and Iowa Highway Safety Patrol; the Delegation of Authority Committee has met on several occasions with nursing representatives, and has been designated to represent the Society on a joint MD/Nurse Liaison Committee; the Drug Abuse Committee has met with the Executive Director of the Iowa State Drug Abuse Authority to discuss drug abuse problems in the state, and ways to alleviate them; and institutional chaplains and seminary representatives in Iowa were guests of the Society at a portion of the 1972 Annual Meeting program dealing with "The Needs of the Dying Patient."

Relations with the press have been strengthened considerably, especially in Des Moines. There have been many contacts and consultations with editorial staff members of the DES MOINES REGISTER AND TRIBUNE for the purpose of explaining and clarifying the Society's position on various health care issues. Of special significance was the opportunity afforded to the IMS to prepare a guest editorial on health maintenance organizations. This editorial was published in the February 4 edition of the DES MOINES SUNDAY REGISTER. Copies of the editorial were reproduced for distribution to all members of the IMS, as well as to all Iowa legislators.

All state press, radio and television outlets receive reprints of the monthly "In the Public Interest" articles from the IMS JOURNAL. This feature comments on various issues and developments in the health field. Members of the Iowa Legislature receive reprints of the JOURNAL articles for their information and resource files.

The Society has maintained its involvement in a series of weekly radio programs on health subjects broadcast over WOI in Ames, and it has participated in the development of special television discussion programs on health topics.

The IMS continues its sponsorship of the Hawkeye Science Fair, along with the DES MOINES REGISTER AND TRIBUNE, Drake University, and the Scanlon Medical Foundation/IMS. The 1973 event for the state's junior and senior high school scientists will be April 6-7 at the Veterans Memorial Auditorium in Des Moines. Last year, almost 700 exhibits were displayed, and participation has increased each year since the Fair was instituted 15 years ago.

The Society also coordinates all arrangements for the "Hall of Health" at the Iowa State Fair. This has become a regular project of the Iowa Health Council.

Late in December, the News Department of the National Broadcasting Company presented a television special titled "What Price Health?" Because of its emotional and inaccurate content, the AMA registered an official protest with NBC, and also filed a complaint with the Federal Communications Commission. In support of the AMA actions, the IMS expressed its strong concern about the program to all NBC affiliate stations in Iowa. In addition, all Iowa NBC stations have been provided a copy of a letter from the Executive Vice President of the AMA to the President of NBC commenting specifically on the numerous inaccurate and misleading statements contained in the program.

The Committee hopes that societies and physicians at the local level will implement projects which seek public understanding and support of medicine's position on various health issues and problems, and stands ready to assist in any way possible.

JOHN G. THOMSEN, M.D., *Chairman*

SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

As has been its custom, the Subcommittee on Interprofessional Activities met with a similar committee of the Iowa Pharmaceutical Association early in the year to consider various issues and questions of mutual concern. It was called to the attention of the Subcommittee, and subsequently to the Society's Committee on Legislation, that the Iowa Podiatry Society will seek to amend the Code of Iowa during the 65th General Assembly to clarify the authority of podiatrists to prescribe controlled substances (drugs). Members of the Subcommittee and other appropriate Society representatives have reviewed the bill, and it will be given careful study as it is considered in the Iowa Legislature.

The Subcommittee wishes to note that, although the American Pharmaceutical Association is officially on record in support of repealing antisubstitution laws, the IPhA has taken no such action. However, in May, the IPhA House of Delegates will act on a specific statement concerning "Drug Product Selection." This statement is intended to promote better patient service and closer working relations between the practicing physician and practicing pharmacist at the local level.

Based on recommendations of the Subcommittee, the Executive Council approved recommendations expressing formal objection to two proposed regulations of the Bureau of Narcotics and Dangerous Drugs—i.e., (1) transfer of "exempt narcotics" from Schedule V to Schedule III, and (2) transfer of nine barbiturates from Schedule III to Schedule II.

Joint meetings between the interprofessional activities committees of the IMS and IPhA will be continued on a regular basis.

Donald L. Taylor, IMS Executive Vice President, continues to serve as Secretary-Treasurer of the Iowa Health Council. The Council consists of the following organizations in addition to the IMS: Iowa Dental Association, Iowa Pharmaceutical Association; Iowa Veterinary Medical Association, Iowa Hospital Association, Iowa Nurses' Association, Health Facilities Association of Iowa, Iowa Society of Osteopathic Physicians and Surgeons and Iowa Podiatry Society. Arrangements for all IHC programs and projects are coordinated through the IMS Headquarters by Mr. Taylor and other staff members. C. E. Radcliffe, M.D., immediate past president of IHC, and S. P. Leinbach, M.D., serve on the Council's Board of Directors, along with Mr. Taylor.

In November, the Health Council sponsored a special conference for designated representatives of its member organizations. Approximately 100 individuals attended the conference which had as its theme, "Sharing a Common Goal—Serving the Consumer." Subjects covered included consumer representation on licensing boards, continuing medical education, quality of care, and professionalism. Because of the success of the meeting, a similar program is to be arranged next year.

The Health Council continues to sponsor and coordinate arrangements for the Hall of Health at the Iowa State Fair, and plans are underway for the 1973 event. In addition, the Executive Director of the Des Moines Science Center has met with the IHC Executive Council to outline plans for a permanent health section in the Science Center. A formal letter has been transmitted to the Science Center advising of the Council's interest in the proposed health section, and of its desire to cooperate in the development in any way possible.

The annual dinner sponsored by the IHC for members of the Iowa General Assembly was February 1. Over 160 legislators, state officials, and member group representatives were in attendance. A formal program was not presented; however, the guests were apprised of the general purpose and activities of the IHC, and it was emphasized that the IHC represents approximately 14,000 individuals involved in health care.

C. E. RADCLIFFE, M.D., *Chairman*

COMMITTEE ON SCIENTIFIC WORK

For the first time in its history, the Iowa Medical Society has scheduled its Annual Scientific Meeting outside of the State of Iowa. This is consistent with an action taken by the 1972 House of Delegates to separate the business and scientific meetings of the IMS.

The Scientific Sessions will be held at Paradise Island, Nassau in the Bahamas, March 29-April 2. The IMS has chartered one aircraft seating 252 persons for the trip, and many physicians are making individual travel arrangements.

An outstanding program has been arranged by the Program Committee, and it has been approved for 11½ hours of elective credit by the American Academy of Family Physicians. Thirteen speakers will participate in a series of lecture and round table discussions covering a broad range of medical topics and problems.

A report on the success of this new education-travel venture will be presented to the House of Delegates at its meeting in April.

KENNETH E. LISTER, M.D., *Chairman*

COMMITTEE ON STATE DEPARTMENTS

Six Society subcommittees contribute their chairmen to the membership of the Committee on State Departments. And it is at the subcommittee level where virtually all of the activity takes place. Each of these subcommittees has a common interest and relationship with one or more divisions of state government. The subcommittees are Aging and Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation and Safe Transportation.

The separate reports of these subcommittees follow these few comments and members of the House of Delegates are encouraged to read them. The reports contain information on a variety of programs which relate to health care in Iowa.

The Committee on State Departments functions in a broad liaison fashion with the State Department of Health. In this connection, it is appropriate to identify the three Iowa physicians who serve ably on the State Board of Health: E. E. Gamet, M.D., Lamoni, P. J. Leehey, M.D., Independence, and P. M. Seebohm, M.D., Iowa City. Dr. Gamet serves as President of the Board. Administrative supervision of the State Department of Health resides with Arnold M. Reeve, M.D., who is now in his fourth year as Commissioner of Health.

Information on matters pertaining to public health

are published regularly in the JOURNAL OF THE IOWA MEDICAL SOCIETY and in other IMS communications.

The Society was represented this past October at a regional meeting staged by the AMA Council on Environmental and Public Health Matters. This meeting was held in connection with an Air Pollution Medical Research Conference. A brief statement on activities in Iowa in this broad area was prepared and submitted for the record.

A. H. DOWNING, M.D., *Chairman*

SUBCOMMITTEE ON AGING & CHRONIC ILLNESS

The Subcommittee on Aging and Chronic Illness has met once this year. E. M. Smith, M.D., Director, Bureau of Medical Services, State Department of Social Services, and A. M. Reeve, M.D., Commissioner of Public Health, met with the Subcommittee.

The Subcommittee was informed of the program which the State of Iowa implemented January 1, 1973, which provides intermediate nursing care to public assistance recipients. The program is required by Public Law 92-223 (1971). This intermediate care facilities program (ICFP) is different in various ways from the skilled nursing home program and covers most public assistance recipients in nursing homes.

Federal statutes define an ICF as ". . . an institution offering health related care and services to individuals who do not require the care and treatment which a hospital or skilled nursing home provides, but who do require institutional care above the level of room and board."

This definition covers two of the seven health care levels provided under Iowa law—Basic Nursing Care and Intermediate Nursing Care. These two types of care are in the middle of the seven levels. The three lower levels are Adult Foster Care, Boarding Home Care and Custodial Home Care; the two upper levels of care are Skilled Nursing and Extended Nursing.

The ICFP will involve some 10,000 Iowa nursing home patients. Nearly all of the 550 nursing homes have one or more public assistance patients. They thus must abide by ICFP regulations. The program goal is to improve the quality of Iowa nursing home care.

The ICFP is required to ". . . provide for a regular program of independent professional review (including medical evaluation of each patient's needs for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility. . . ." This has been interpreted to include, with modification, prior authorization, medical review and utilization review features of the skilled nursing home program.

Prior authorization or planned admission under ICFP will require physicians to complete a medical form on each state assistance patient admitted to a nursing home. This form must include a diagnosis and plan of treatment. The physician must determine and certify the most appropriate level of care. These certifications will be reviewed for completeness and guideline conformity by the State Department of Social Services. Title XIX regulations specify a medical necessity for nursing services must exist if there is to be admission and reimbursement. As a result of this, physicians should know the alternative care facilities and services available in their areas. Services which allow the recipient to maintain independent living should be known and encouraged. HEW funds may be used only for medically necessary admissions to nursing homes.

The utilization and medical review programs will require physician cooperation. Nursing homes must have an outside physician on their UR committees. On-site medical reviews are to be conducted by special review teams. Physicians will be notified when a medical review of one of their patients is to be conducted. Physician attendance is optional.

According to the DSS, the primary purpose of the prior authorization and medical review procedures is to insure that nursing homes are providing the type and quality of care prescribed by physicians. A complex reimbursement formula is used to determine the payment to the facility.

The Subcommittee has reported to the IMS Executive Council on the implementation of this program. The Council acknowledged the program and approved support of the SDSS in its implementation.

The Subcommittee has also discussed (1) nutrition for the aged, (2) the declining status of the tumor registry, (3) sickle cell anemia, (4) renal dialysis, and (5) the financial impact of a catastrophic illness. The Subcommittee expressed considerable concern over the cost of long term illness and felt a stand should be taken by the Society on this subject.

E. E. LINDER, M.D., *Chairman*

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

Most recently, the Subcommittee on Maternal and Child Health has concerned itself with reports from the State Department of Health on the increased incidence of rubeola (1,592 cases reported). Of these cases better than 900 have occurred in school-centered outbreaks in seven counties. It is estimated by the Department that 25-35% of the children in Iowa are not being routinely vaccinated for rubeola.

In an effort to assist local health authorities with measles outbreaks, the Preventive Medical Service of the State Department of Health has devised supportive approaches which may be called on at a moment's notice. Information on this subject has been brought to the Subcommittee by Charles Herron, M.D., Director of Infectious Disease Control. The following statement was submitted to the IMS Executive Council in January by the Subcommittee and was subsequently approved:

The Iowa Medical Society notes with some concern the recent reappearance of rubeola in school-centered outbreaks in Iowa. Because this disease causes significant discomfort and carries a significant risk of acute and chronic complications to affected individuals, all reasonable attempts should be made to interrupt its transmission at the earliest possible moment. The Society therefore takes pleasure in calling the attention of its members to the "Rapid Response to Measles Program" now offered by the Iowa State Department of Health to assist the various county medical societies in meeting this problem. The Iowa Medical Society strongly recommends that county medical societies avail themselves of the "Rapid Response to Measles Program" in order to minimize rubeola morbidity in Iowa.

Word of this action has been transmitted to the membership through several Society communications. In its consideration of this matter, the Subcommittee agreed that local physicians should *not* be bypassed in the undertaking of any expeditious and broad program. The Subcommittee has also reminded itself of those So-

ciety approved guidelines which cover the administration of vaccines.

The Subcommittee has also met with Elmer M. Smith, M.D., Director, Bureau of Medical Service, State Department of Social Services, regarding new provisions in the Medicaid program which require the early and periodic screening, diagnosis and treatment of children under 21 years of age. This program began July 1, 1972, and included children up to age six. As of July 1, 1973, those between 7 and 21 will be incorporated into the program. There are estimated to be 62,000 Iowans under 21 on Aid to Dependent Children who could be involved in the program.

Regulations require that screening and diagnosis be done for a wide range of physical and mental defects to include: measurements; physical inspection; developmental assessments; vision screening; hearing screening; ear, nose, mouth and teeth inspection; hematocrit or hemoglobin; rapid urine screening; immunization review, etc.

A report on this program was presented by the Subcommittee to the Executive Council in July 1972. The Council received the information and instructed the Society to cooperate with the State Department of Social Services as it implements this mandatory aspect of the Medicaid program.

In a further recommendation supported by the Executive Council, the Subcommittee called for the Society to cooperate with the State Department of Health in its efforts to make mandatory premarital testing for rubella antibodies. It was stressed during discussion, and in response to concern expressed by members of the Committee on Independent Laboratories, that the testing not be limited to the State Hygienic Laboratory.

The Subcommittee has also (1) recommended continued IMS participation in the Iowa Youthpower Project, (2) continued affiliation with the Nutrition Council of Iowa, (3) noted and encouraged education efforts related to venereal disease, (4) discussed, but taken no action, on the status of the Maternal Mortality Committee, (5) considered briefly merits of an IMS-sponsored quality of life conference similar to a recent national AMA meeting, and (6) acknowledged the existence of the Great Plains Association for Perinatal Care.

G. L. BAKER, M.D., *Chairman*

SUBCOMMITTEE ON PSYCHIATRIC CARE

The Subcommittee on Psychiatric Care has continued to follow developments which relate to the delivery of care for nervous and mental diseases in Iowa.

In January the Subcommittee submitted the following two requests to the IMS Executive Council:

(1) Request the IMS Executive Council to reaffirm that psychiatry is a well-recognized medical specialty and should be so considered in the evaluation and endorsement of any legislation pertaining to HMO's; specifically, it is recommended that psychiatric care be considered an important part of and included in any and all HMO programs which may evolve in Iowa; further, as there are specific questions which occur regarding the scope of services to be embodied in an HMO, particularly relating to mental health care, it is the request of the Subcommittee that it be assigned to study these matters and offer recommendations. (The Executive Council accepted this as information.)

(2) Request the IMS to oppose a legislative proposal (Bill 4A—Mental Health Legislation) which proposes to establish a separate State Department of Mental Health and Mental Disabilities. The Subcommittee believes the proposal would have a deleterious impact on mental health care delivery in Iowa. A statement on this matter developed by the Iowa Psychiatric Society was provided to members of the Council. (The Council agreed the Legislative Committee of the IMS should be directed to aid in impeding passage of Bill 4A.)

In another legislative matter, the Subcommittee, through its involvement with the Joint IMS-Iowa Bar Association Committee, has taken steps to obtain General Assembly support for the emergency commitment legislation which has been drafted by the joint committee and which has the approval of the IMS and IBA. Representatives of the Society and Bar have met with two state legislators to seek their support.

The joint committee has continued its evaluation of the long-term commitment statutes which now exist and has considered further the need for revising these laws. In this connection a model draft act governing hospitalization of the mentally ill is being evaluated and adapted for possible use in Iowa. However, there is a feeling within the Subcommittee that with passage of the emergency commitment measure, the balance of the existing statute could remain intact. It was felt that a study of the way in which the various hospitalization commissions function might be useful in this overall consideration.

The Subcommittee has indicated its desire to step up its consideration of this and other subjects pertaining to mental health care in Iowa.

W. A. BOCKOVEN, M.D., *Chairman*

SUBCOMMITTEE ON PUBLIC ASSISTANCE

The Iowa Medical Society has continued to work with the State Department of Social Services on matters pertaining to the Iowa Medical Assistance Program (Title XIX/Medicaid). The Subcommittee wishes to compliment Elmer M. Smith, M.D., Director, Bureau of Medical Services, SDSS, and his associates, for their conscientious efforts in overseeing the Iowa Medicaid Program.

In 1972 Iowa Medicaid expended $25.9 million with 58.07% of this coming from federal sources and 41.93% from state funds. Of this sum, $5.7 million (22.1%) was paid to medical doctors; osteopathic physicians received nearly $1.1 million (4.2%). Other principal providers received reimbursement on the following percentage basis: hospital inpatient—32.1%; pharmacies—21%; dentistry—9.8%; and skilled nursing homes—1%.

The number of Medicaid recipients who received service from MD's in December 1972 totalled 20,619 with the cost per recipient averaging $21.69. Included were 59,425 physician visits in the office, hospital, home, nursing home, etc. The average MD cost per claim for December was $17.21.

Attention is directed to the report of the Subcommittee on Aging and Chronic Illness where there appears a summary of the new program which provides intermediate nursing care to public assistance recipients. This program is required by Public Law 92-223 (1971) and began January 1, 1973. This new program calls for a revised reimbursement procedure for those public assistance recipients who reside in an intermediate care facility.

The new Intermediate Care Facilities Program (ICFP) is seeking to improve the quality of Iowa nursing home care and provide (1) a regular means for independent and professional review of each patient's needs, and (2) a written plan of service before admission and benefit authorization.

The IMS Executive Council has been advised of this program and has requested the Society to be supportive of the SDSS in its implementation.

Additionally, as is noted in the report of the Subcommittee on Maternal and Child Health, the early and periodic screening, diagnosis and treatment of children under 21 years of age will be extended as of July 1 to cover Aid to Dependent Children (ADC) recipients who are between the age of 7 and 21. For the past year the program has involved children up to six years of age. This program has likewise been reported to the IMS Executive Council and instruction was given to cooperate with the SDSS in its implementation.

The Medical Assistance (Title XIX) Council continues to exist with the chairman of this Subcommittee serving as the IMS representative. Also, the chairman is a member of the Formulary Advisory Committee to the SDSS. Neither of these bodies has been active this year. Even so, the SDSS has continued to urge caution in the prescribing of medications, both from the therapeutic and economic standpoints. Certain restrictions have been imposed with respect to drugs. For example, payment will not be approved without prior approval for amphetamines or for legend multiple vitamins, tonic preparations or combinations thereof.

Several modifications in the Medicaid program will be imposed as a result of the Social Security Amendments of 1972. For instance, a reduction is possible in federal Medicaid matching for services in some facilities for lack of proper utilization and medical review methods. Also, the requirement that each state broaden its scope of care and services under Medicaid and liberalize the eligibility requirements has been eliminated.

A. J. HAVLIK, M.D., *Chairman*

SUBCOMMITTEE ON REHABILITATION

The Subcommittee has not had occasion to meet this year. There is however one matter which will be of interest to Iowa physicians.

In the Social Security Amendments of 1972 (H.R. 1), Section XVI provides for Supplemental Security Insurance Benefits. Under this federal measure, which must be operative by July 1, 1973, a contract must be negotiated between the federal and state governments assigning to one state agency responsibility for determining eligibility of those applying for benefits under the Aid to the Blind (AB) and Aid to the Disabled (AD) programs.

Initiation of this program will require state enabling legislation and assignment by the Governor of administrative duties to a state agency. It appears likely the Social Security Disability Determination Division (DDD) of the Iowa State Rehabilitation Agency may be assigned this responsibility. Heretofore, applicants for AB and AD were processed through county welfare departments and eventually the State Department of Social Services.

Under this new plan it is predicted that as many as 10,000 examinations will be required in a year's time of those applying for these benefits. The designated state agency must certify, based on medical evidence submitted, that the applicant is eligible for benefits. The program provides for reimbursement to physicians for these examination services. The state agency assigned to administer the program will be required to follow federal guidelines.

More specific information will be provided to Iowa physicians on this matter as additional decisions are made.

Homer E. Wichern, M.D., Des Moines, continues as Chief Medical Consultant, Disability Determination Unit, Iowa Division of Rehabilitation Education and Services.

C. B. LARSON, M.D., *Chairman*

SUBCOMMITTEE ON SAFE TRANSPORTATION

The Subcommittee on Safe Transportation has met on two occasions in recent months with Michael Sellers, Commissioner of Public Safety, and other officials of the Department and the Iowa State Highway Patrol.

In evaluating the effectiveness and operation of the Medical Advisory Board to the DPS, the Subcommittee was assured by Commissioner Sellers that it serves a valuable and useful service, and should be maintained. Consistent with a joint agreement developed between the IMS and DPS in 1966, the Medical Advisory Board was created to review and make recommendations on medical reports required by the Department on certain driver's license applicants. To date, 37 cases have been reviewed by the Board, and its recommendations have been referred to the DPS.

There is agreement by both the Medical Advisory Board and DPS officials that the anonymity of the Board must be maintained in order to assure its continued effectiveness and service; further DPS officials have indicated that under no circumstances would the Department release the names of Board members.

Based on a discussion which occurred during one of the joint meetings, the DPS has announced that its policy with respect to issuing driver's licenses to persons with epilepsy has been revised. The new ruling is as follows: "Under the authority of 321.177(7), Code of Iowa, it shall be the policy of the DPS not to license a person who suffers from epilepsy until such person has remained seizure free for a period of *one* year, and then only upon receipt of a satisfactory medical report from a physician. Such medical report must be on a form furnished by the Department, and must contain such information as requested, including the physician's recommendation toward licensing. If the medical report is satisfactory, the person will be licensed for a period not to exceed three years. After one year of such driving privilege, another medical report must be furnished to the Department. If this report shows the person has remained seizure free since the previous medical report, and if the physician again recommends that the patient be considered for licensing, he will then be licensed in the usual manner, subject to such rules as the Department deems applicable. Each application for a license thereafter must be accompanied by a satisfactory medical report."

The Subcommittee has been authorized to arrange and conduct a Conference for District Supervisors and Headquarters Personnel of the Highway Patrol. This meeting will provide a forum for the discussion of problems and for the exchange of ideas on reducing automobile injuries and fatalities in the state.

A recommendation of the Subcommittee relating to legislation proposed by the DPS to clarify the existing Implied Consent Law has been presented to the Society's Legislative Committee. Subsequent conferences between representatives of the Legislative Committee and the Chairman of the Safe Transportation Committee have brought agreement the Society should continue its support of the blood test as the most desirable and accurate measure of determining the amount of alcohol in the blood of a driver arrested and charged with Operating a Motor Vehicle While Under the Influence of

Alcohol; further, in reference to breath alcohol tests, they are suitable and produce highly accurate results under properly controlled conditions, which include suitable methods and equipment, proper training and continuing expert supervision of competent operators and adequate control by professionals of equipment reagents and procedures. This information has been provided to the Commissioner of Public Safety.

A. H. DOWNING, M.D., *Chairman*

PUBLICATIONS COMMITTEE

The JOURNAL OF THE IOWA MEDICAL SOCIETY has completed another year of service to the physicians of Iowa. In doing so it is our hope we have provided the membership reading material which is interesting, relevant, accurate and readable. The objective of the editors has been to present a balance between scientific and socio-economic content. In an effort to present a dynamic and current face, we have introduced one or two new features, have continued our program of face-lifting and have abandoned one or two regular entries which may have run their course for the time.

As an example of our efforts to be innovative, we presented the entire scientific section of the February 1973 issue in the form of a renal disease symposium. This material was purposely coordinated with a series of renal disease conferences for physicians now being held about the state. We are indebted to W. W. Bonney, M.D., for his assistance with this effort.

The interests of the JOURNAL continue to be ably represented at The University of Iowa College of Medicine by Richard M. Caplan, M.D. We are grateful to him for stimulating excellent and diversified scientific material from the academic community. We are also most pleased to have editorial contributions from those other Iowa physicians who are busy private practitioners. We encourage, admire and appreciate the authors who fall into this category.

Please be assured the Publications Committee and your editors will seek to provide for Iowa physicians a vibrant, sometimes provocative, if not massive, medical journal. We invite you to submit your suggestions, case reports, scientific manuscripts and news items to the JOURNAL at any time.

MARION E. ALBERTS, M.D., *Scientific Editor*

Reports of Special Committees

COMMITTEE ON ALCOHOLISM

The Committee on Alcoholism has continued to be involved principally in educational activities, particularly those which concern youth. At one of its three meetings (November 9) in the 72-73 Society year, the Committee hosted approximately 25 high school students who participated in summer workshops on alcohol or other addictions, either in Iowa City or Storm Lake. The youth shared informally with the Committee their reactions to the summer education experience and the subsequent opportunity to use gathered information in home settings.

Participants in this meeting, in addition to the students, were Harold Mulford, Ph.D., Director of the Oakdale Alcohol Unit and Director of Alcohol Studies at the University of Iowa; and Jeff Voskans, Director, Northwest Iowa Alcohol and Drug Treatment Unit.

It will be recalled sponsorship of workshop attendance by young people was sought of county medical societies last year. In all, between 20 and 25 students did participate under some form of medical auspices. The Scanlon Medical Foundation/Iowa Medical Society provided grants for four students. An invitation has been circulated to the county medical societies inviting sponsorship ($75) of a student for the 1973 program to be held at Buena Vista College June 11 to 16. Five affirmative responses have been received to date. It is hoped more will be forthcoming. The suggestion is made that a tenth or eleventh grade student be chosen so he or she will have an opportunity to share formally and informally the information gathered during the ensuing school year.

The Committee was impressed by the overall perception and depth of understanding of the young people with whom it met in November. While they expressed apprehension about speaking formally to various groups, the students indicated they had had occasion to use their knowledge, and they mentioned with particular satisfaction appearances before elementary and junior high students. The Committee was pleased to have had Ralph L. Wicks, M.D., chairman of the IMS Board of Trustees, present for a portion of the November meeting.

It is the sincere hope of the Committee that involvement of youth in this educational way can grow to a point where in 10 years a cadre of well-informed young people will be available to provide leadership in local alcohol education. The philosophy of the Committee, imparted to the students, has been one of encouraging the intelligent use of alcohol, if at all, and not portraying it as a totally bad practice.

In other 1972-73 projects, the Committee assisted with the presentation of an educational exhibit at the Iowa State Fair which illustrated the effects of alcohol on the vision and reflexes of the automobile driver. The Iowa Commission on Alcoholism cooperated in this project. As implied in the preceding comments, the Iowa Medical Society, on the Committee's recommendation, will be a co-sponsor of the 1973 Northwest Iowa School on Chemical Substances and Other Addictions to be held in Storm Lake. The Committee has followed developments (1) in the re-organization of the Oakdale Alcoholism Center; (2) in the early implementation of the new federally-funded Iowa State Alcoholism Plan (Dr. F. W. Bennett is member of the Advisory Committee); and (3) leading to future educational presentations at meetings of various medical groups.

The Committee had discussed briefly the possibility of applying for public funds to support its efforts in the youth education area. It has been advised to proceed on the present limited basis for now.

The Committee is pleased to report on a rather productive year.

S. M. HAUGLAND, M.D., *Chairman*

COMMITTEE ON ARCHITECTURAL EDUCATION

The Committee on Architectural Education, in joint session with representatives of the Iowa Chapter/ American Institute of Architecture, has developed a set of guidelines and procedures for use by those involved in hospital/health facility planning. This project was undertaken to define the steps which must occur in any hospital or health facility building program to assure the structure will most effectively meet the needs of those who provide health care, and the recipients of that care.

The Committee was recently authorized by the Board

of Trustees to retain the services, at a minimal cost, of a graduate student in the Department of Architecture at Iowa State University, to refine the material developed by the Committee, including the use of graphics. Representatives of the Iowa Hospital Association will be invited to meet with the Committee to review and comment on the proposed guidelines. The document will then be submitted to the IMS Executive Council and, if approved, ultimately made available to the memberships of the IMS, Iowa Chapter/AIA and IHA.

In order to avoid problems and pitfalls in a hospital/health facility building venture, and to assure a functionally sound and aesthetic structure, the Committee is strongly emphasizing in the proposed document that 1) there be a broad base of physician participation in the initial planning; 2) the architect who designs the facility should have early access to and consultation with the physicians who will utilize it, and 3) there should be continuing contact between the physicians, the architect, and the facility administrator.

JAMES E. KELSEY, M.D., *Chairman*

COMMITTEE ON BLOOD BANKING

The Committee on Blood Banking has not met formally under the Iowa Medical Society auspices during the past year, however, all members have been actively engaged in the consideration of state-wide blood banking problems. Most Committee members attended a lengthy meeting on blood supply problems held in Iowa City following the fall meeting of the Iowa Association of Pathologists last November.

Principal problems within the state regarding blood supplies have been presented to the Iowa Medical Society membership in the annual reports on several occasions. It has been difficult to secure and maintain adequate supplies of blood in Des Moines and in Iowa City for use at the University. Significant progress, however, has been made at the University under the leadership of the Pathology Department. The donor facilities have been doubled. The replacement program has been stimulated. Working arrangements with community blood banks in the state are gradually evolving. The purchase of "commercial" blood outside of Iowa was discontinued about one year ago. The finest available techniques for hepatitis screening are in use. The Red Cross has provided increased amounts of blood to satisfy discrepancies occurring between requirements and intra-state resources.

The American Association of Blood Banks has urged its member banks to work toward a goal of 100% voluntary donors by the end of 1975. This goal is already a fact in several of our larger Iowa communities which persuades us strongly that a coordinated state-wide voluntary system could become a reality. Funding and availability of full-time leadership would be essential prerequisites to a state coordinated program. The supplies of emergency blood and donor resources to smaller rural hospitals could be assisted significantly by developing a system of regional blood banks. We will continue to search for means of implementing these goals.

Responsibility for development of a national blood policy has been delegated to the Director of the National Heart and Lung Institute. We have had an opportunity recently to review the proposed national policy. Significantly it places considerable emphasis upon the development of an all voluntary blood donation system and elimination of commercial relationships between donor and blood bank which have encouraged reliance on blood from sectors of society in which transmissible hepatitis is particularly prevalent.

The proposed national policy calls for development of short range and long range implementation plans. The former are due by May 15, 1973 and provide for input from "associated agencies of government together with their advisors." Present economic and administrative aspects of blood banking will undoubtedly receive critical examination. We urge that presently successful motivational systems for donor recruitment not be eliminated. Because the non-replacement fee is refunded or credited to patients upon receipt of blood donation or of pre-established donor credit (blood assurance plans) it may well be the single most important reason why voluntary donors contribute blood. We also urge that purchase of blood from carefully screened and selected quality donor populations not be excluded as an option for blood banks operating under appropriate inspection and accreditation systems. Several members of this Committee agree that criteria for "good" and "bad" blood should be primarily based upon careful donor selection and scientifically valid tests to detect hepatitis-associated antigen rather than on the basis of remuneration for blood. This nation has had a bad experience by allowing commercial blood banks to run rampant without adequate controls. We should not now allow this experience to cloud our thinking as we work to establish proper criteria for an effective, efficient national blood program which will assure the highest attainable standards of practice in blood banking.

W. S. PHETEPLACE, M.D., *Chairman*

COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

This Committee is comprised of representatives from the Society's Committees on Safe Transportation, Rural Health, and National Emergency Service. This composition was determined in order to assure appropriate liaison and communication between IMS entities with overlapping interests.

A year ago, A. H. Downing, M.D., was appointed by the Governor to represent the IMS on a Statewide Emergency Medical Service Advisory Council. The Council has met regularly and has appointed four task forces in the areas of communications, hospital emergency facilities, emergency personnel and training, and ambulance service organization and operation. Several other physicians are involved in the work of the Advisory Council and its task forces. Two progress reports on the work of these groups have been published in the IMS JOURNAL (December 1972 and January 1973).

In one of its major projects, the Advisory Council is currently attempting to categorize hospital emergency rooms throughout the state, and a questionnaire has been mailed to 130 hospitals seeking information in this regard. Guidelines established by the AMA with respect to categorization of hospital emergency rooms are being used as a resource.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON COMPONENT BILLING

By action of the 1972 House of Delegates this special committee has been created to explore further the question of payment for surgery and surgical assistants under Medicare. The 1972 House refused to rescind its action of 1970 which approved the five component billing system for treatment of a surgical illness but suggested the Committee consider the establishment of three components as follows: (1) patient work-up; (2)

preoperative care, surgery, and post-operative care; and (3) surgical assistant.

The Committee is aware, as acknowledged by the House, that the new five component system has been in existence such a short time that it has not had an opportunity to prove or disprove its capabilities in providing profiles of charges. The Carrier will soon present a progress report to the Committee which will be helpful in making a complete and objective evaluation of the subject.

A supplemental report will be presented to the 1973 House of Delegates outlining the results of the Committee's study and setting forth any specific recommendations.

L. L. ZAGER, M.D., *Chairman*

COMMITTEE ON DELEGATION OF AUTHORITY

A special Committee on Delegation of Authority was appointed in June 1972 by the President to meet with representatives of the Iowa Nurses' Association and the Iowa Board of Nursing to consider questions pertaining to the delegation of authority by physicians to nurses and others. In an effort to give official recognition and identity to the efforts to strengthen and enhance the relationship between medicine and nursing at the state and local levels, the members of the Delegation of Authority Committee have been designated to serve on a Joint MD/Nurse Liaison Committee, along with representatives of the INA and Board of Nursing.

Since June three joint sessions have occurred and attention has been given to such subjects as the extension of the nurse's role in patient care. Also considered has been the training and role of physician's assistants in Iowa. A. W. Horsley, M.D., Assistant Dean, Allied Health Programs, University of Iowa College of Medicine, attended the meeting in January, and provided detailed information on the development and operation of the PA training program initiated by The U of I last fall.

At the meeting in January, attention was called to questions concerning ear piercing procedures performed in non-medical settings. Based on a recommendation of the liaison committee, the IMS Executive Council subsequently approved a statement recommending that "persons wanting to have their ears pierced should have the procedure performed under maximum safety in a physician's office."

The Chairman of the Delegation of Authority Committee, along with officials of the Iowa Nurses' Association, attended a program sponsored and arranged by the Joint Practice Committee on Medicine and Nursing held in Chicago, November 9-10.

On recommendation of the Society, the Governor has appointed the Committee chairman to serve on a Commission to Study Nursing in Iowa. This Commission will be called upon to assist in the identification and analysis of the many vexing problems confronting nursing in Iowa.

OFFICIAL ISSUE

The July JOURNAL is designated the official issue and carries the proceedings of the 1973 Annual Session of the House of Delegates of the Iowa Medical Society.

The joint sessions will continue on a regular basis so physicians and nurses can maintain an appropriate and official forum to consider and discuss issues and problems of mutual concern.

L. F. STAPLES, M.D., *Chairman*

COMMITTEE ON DELIVERY OF HEALTH SERVICES

The primary responsibility of the Committee on Delivery of Health Services is to consult and maintain liaison with The University of Iowa College of Medicine as model health care delivery programs are developed—e.g., the Model Rural Health Center at Oakdale and the Community Health Center in Muscatine.

Last spring the Committee met at the Family Practice Clinic on The U. of I. Oakdale Campus. A briefing on the function of the Clinic was presented by Robert Rakel, M.D., Head of the Family Practice Department. Information was also provided on preliminary plans for the operation of the Muscatine Community Health Center. As a result of the Committee meeting, the following recommendation was presented to and approved by the IMS Exeeutive Council: That the IMS support these innovative experiments in health care delivery, and assist in their development; further, that meetings of the Committee with appropriate College of Medicine officials involved in these programs be continued.

In December 1972, the Committee conferred with A. W. Horsley, M.D., Assistant Dean, Allied Health Programs, and John MacQueen, M.D., Associate Dean, University of Iowa College of Medicine. Dr. Horsley presented a progress report on the Muscatine Community Health Center. This Center will function as an ambulatory care center and will be used to train medical students, interns, residents, and students enrolled in the new Physician's Assistant Training Program. A community health center organization has been formed in Muscatine with physician representatives. Local physicians will serve as a core faculty. The Center is to be a model which can be used as a pattern elsewhere in the state. Target date for opening the Muscatine Center is July 1, 1973. After it becomes operational, the Committee plans to make an "on-site" visit.

The Committee has reviewed a report titled "A Proposed Organizational Structure for Providing Health Services and Medical Care in the State of Iowa" prepared by Dr. MacQueen and Eber Eldridge, Ph.D., Professor of Economics, Iowa State University. The report has been approved as a concept by the Health Manpower Committee of the State Advisory Council/Office for Comprehensive Health Planning. It contains suggested organizational units through which health services could be provided, as well as demographic data and information about physicians in 16 designated regions in the state.

It is understood and emphasized that there is no intent or attempt to enforce compliance to the regions and health centers as outlined in the proposed organizational units. On the contrary, the plan should not and cannot be created by legislative action; rather, any new arrangements must be developed by those immediately involved in providing health services and by the recipients of those services.

Based on a recommendation of the Committee, the Executive Council has authorized the IMS to co-sponsor a series of regional meetings to be held to consider long-range health plans for various areas in the state, utilizing the "Proposed Organizational Structure" only

as a basis for discussion. Representatives of the Committee and/or officials of the IMS will serve on a planning committee to assist in developing a program format and making specific arrangements for the regional meetings. One previous series of meetings was held in 1968 to encourage physician discussion of the manpower situation in the state. Another series was offered in 1969 so physicians, allied health personnel and community leaders could discuss not only medical manpower problems but the need for local health planning as well.

MAX E. OLSEN, M.D., *Chairman*

DRUG ABUSE COMMITTEE

The Drug Abuse Committee has met with Mr. Fred Brinkley, Jr., Director of the Iowa Drug Abuse Authority, to discuss matters of mutual interest and concern. Mr. Brinkley was advised of an action taken by the IMS House of Delegates in April, 1972, urging physicians to limit the use and prescribing of amphetamines, except in cases of accepted indication. His attention was also called to the following statement on marijuana, approved by the AMA House of Delegates in June, 1972: "The AMA House of Delegates does not condone the production, sale, or use of marijuana. It does, however, recommend that the personal possession of insignificant amounts of the substance be considered at most a misdemeanor, with commensurate penalties applied. It also recommends its prohibition for public use, and that a plea of marijuana intoxication should not be a defense in any criminal proceeding."

The Committee has been apprised of a bill introduced into the 65th Iowa General Assembly to establish by statute the Iowa Drug Abuse Authority. The IDAA was created originally by executive order. The bill assigns responsibility for planning and coordinating drug abuse prevention functions to a single state agency—i.e., the IDAA, which can work collaboratively with community groups, state agencies, and the federal government. It also provides for the creation of a state advisory council consisting of 35 members, 13 of whom will be ex-officio, including a representative of the IMS. The IDAA would be responsible for developing a comprehensive state plan for drug abuse prevention, and would be eligible to receive financial support from the federal government to assist in implementing its programs.

The Committee believes, in an effort to eliminate drug abuse problems, major emphasis should be placed on prevention and education programs, and Mr. Brinkley concurs with the Committee. However, the Committee acknowledged that what is necessary and important is a sufficient number of well-trained individuals who can communicate effectively with youngsters—and adults.

The Committee is concerned about increasing public acceptance of the use of various forms of drugs as an easy way to solve human problems. It has discussed the prescribing of drugs by physicians, and the need for physicians to exercise caution in this regard, in order to reduce the reliance on drugs as a "resolver" of human problems. In an effort to focus the attention of physicians on drug prescribing practice and drug abuse problems, the Committee is preparing a special editorial for publication in the IMS JOURNAL.

The Committee is exploring the possibility of scheduling a program on the subject of drug abuse over WOI-TV.

In June 1972, the IMS mailed to the membership copies of a manual titled "Practitioners Informational Outline of the Controlled Substances Act of 1970." The manuals were obtained from the Bureau of Narcotics and Dangerous Drugs.

F. W. BENNETT, M.D., *Chairman*

COMMITTEE ON EYE CARE

No specific matters were referred to the Committee during the past year and therefore no meetings have been held.

The Committee will stand-by to consider questions relating in particular to relationships between physicians, optometrists and opticians.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON GROUP INSURANCE

Two meetings of the Committee on Group Insurance have occurred this year. There has been excellent attendance on both occasions.

The Committee has given principal attention to the nervous and mental provisions of the Statewide Physicians Group Program. The extreme plight of one Iowa physician which resulted from a reduction in hospitalization for psychiatric care (from 365 to 30 days) was brought to the attention of the Committee this fall. This curtailment was made unilaterally in 1971 by Blue Cross/Blue Shield. The impact of the action became known only after the tragic experience of the physician mentioned above. The Committee has told Blue Cross/Blue Shield officials of its extreme displeasure with this development.

After reviewing the matter with Blue Cross/Blue Shield representatives at two meetings, the Committee instructed the Blue Cross coverage for inpatient nervous and mental coverage be restored to 365 days. The Committee has been advised this restoration will occur April 1, 1973, the beginning of a new quarter. The Committee concluded the slight additional charge ($1.50 single and $1.70 monthly) would be acceptable to the participating members.

Word of this action has been sent to the participating physicians along with an enclosure from BC/BS outlining the cost and timing of the restoration.

Several more major modifications in the present Statewide Physicians Group have been discussed by the Committee, but action to this point has been limited to correcting the mental health deficiency. BC/BS has been requested to make an analysis of the IMS group as to participants, total number served, age spread, etc. The Committee will meet again when this data is available to consider ways of improving the program.

Representatives of The Prouty Company have reported to the Committee on the Society insurance programs which they administer. Two new group plans have been offered to IMS members this year and one additional sponsored program will be made available in 1973.

The sponsored Office Overhead Expense Disability Plan and the individual Excess Major Medical Plan have attracted the interest of a number of IMS members and they have met the minimum underwriting requirements during the chartered enrollment periods. The Committee has noted with satisfaction that access to this low cost insurance protection without evidence of insurability is a significant benefit of Society membership.

The Prouty Company has advised the charter enrollment for the IMS-sponsored In-Hospital Indemnity Plan will occur this spring. This plan will provide extra income when hospital confined. Coverage begins the

first day of hospitalization and pays up to 365 days for each sickness or accident. The plan pays regardless of other insurance. Coverage is intended to fill any "gaps" in personal or group medical insurance. Benefits are available from $20 to $60 per day and coverage is provided on a guaranteed renewable basis to age 70. During the charter enrollment period, if a sufficient number of insurable applicants enroll, all members may apply for the basic daily benefit without evidence of insurability.

In addition to these newer programs, The Prouty Company continues to offer the Guaranteed Renewable Accident and Sickness Disability Income and Group Life Insurance Programs. Both afford interested physicians various options.

Other coverages for the IMS member, his family and office personnel are available from The Prouty Company. These coverages include High Limits of Accidental Death and Dismemberment, Life Insurance for the Woman's Auxiliary to the IMS and "Gal Friday" Disability Income Protection for Employees.

The Accident and Sickness Disability Income Plan is reported to have encountered problems over the past several years. In five years $746,000 have been collected in premiums and $847,000 have been paid in claims and expenses, representing a 113 per cent loss ratio. This is a national trend and corrective measures must be taken. The following steps are anticipated: (1) premium rates will be reduced for members under 40, and (2) an increase will be instituted for those over 40 with a slight increment with each subsequent renewal. The low premium cost for young members will be beneficial to them and will provide the program with the age spread needed. No change in premium structure is anticipated until June.

In view of the new coverages and improvements which have been made, The Prouty Company has indicated to the Committee it is happy to present informational programs to any interested county medical societies during 1973. Arrangements for this may be made through IMS Headquarters or directly with The Prouty Company.

R. S. GERARD, M.D., *Chairman*

COMMITTEE ON HEALTH PLANNING PROGRAMS

The Committee on Health Planning Programs did not meet this year. However, the Society has continued its liaison with the Health Planning Council of Iowa, Office of Comprehensive Health Planning and the Iowa Regional Medical Program.

Several Society members have been actively involved in the various health planning programs. John Sunderbruch, M.D., has served as the vice chairman of the Iowa Regional Advisory Group; John Tyrrell, M.D., has served as IRAG treasurer; Terry Dynes, M.D., and E. A. Larsen, M.D., served as the two other IMS representatives to IRAG; both served as committee chairmen. Dr. Sunderbruch and D. J. Soll, M.D., represent the IMS on the OCHP Advisory Council. Your Committee chairman served as president of the Health Planning Council of Iowa for 6½ years. The post was relinquished last fall, but service has been continued as a member of the HPCI Board of Directors.

Two developments in the health planning field are worth special note. Both involve the phasing out of planning programs. In January 1973, the HPCI decided it had accomplished its primary purpose and should therefore disband. The Committee is disappointed to see the demise of the only voluntary planning agency in the state; on the other hand, we wish to extend our deepest feelings of appreciation and gratitude to the members and staff of HPCI for a job well done.

We are all aware of the recent cutbacks in federal programs. One victim of the federal withdrawal is the Iowa Regional Medical Program. All state RMPs have been ordered to begin phasing out operations by June 30, 1973. It appears now that present programs funded by IRMP will remain on a priority basis, but all programs will be phased out by February 15, 1974.

Obviously, the emphasis and responsibility for health planning will now reside with the State Office for Comprehensive Health Planning. IMS representatives will continue their involvement with OCHP. However, it now becomes imperative that IMS members make an extra effort to become involved in local health planning. Expert medical advice and leadership must be present as health planning programs are developed and implemented.

HOMER L. SKINNER, M.D., *Chairman*

HISTORICAL COMMITTEE

Since the last Annual Meeting, the Historical Committee has met twice with officials of the Iowa State Historical Society to discuss ways of encouraging and assisting physicians interested in preparing medical history manuscripts.

The Committee recognizes that physicians who are willing to devote their time, talent, and effort to writing projects do perform a great service in recording Iowa medical history. Such historical documents are of great interest to county and state historical societies, The University of Iowa College of Medicine library, other state medical libraries, etc.

The Committee intends to develop a pamphlet with a set of guidelines or "helpful hints" to 1) stimulate physicians to research and write about medical history; 2) provide cost estimates for publishing manuscripts; and 3) suggest ways of seeking financing for such writing projects.

The Committee wishes to acknowledge two comprehensive and excellent medical history manuscripts titled "History of Medicine in Boone County" and "It Was Salubrious—A Chronicle of Midwest Medical Practice, Progress, Opinion—1856-1892." The authors are H. W. Longworth, M.D., of Boone, and G. E. Morrissey, M.D., of Davenport, a Committee member.

The IMS will assist in producing limited quantities (25-50) of historical manuscripts submitted to the Historical Committee by physicians. These copies will be for use by the author and the Society.

Members of the Committee continue to prepare short articles which describe changes in scientific medicine and in medical practice over the years. These are published as brief features in the IMS JOURNAL under the heading "I Remember When. . . ."

OTTO N. GLESNE, M.D., *Chairman*

COMMITTEE ON HOUSE OF DELEGATES APPORTIONMENT

By action of the 1972 House of Delegates a special Committee on House of Delegates Apportionment was created. The Committee was requested to study several items pertaining to IMS structure and report its findings. The subjects to be considered were these:

1) Structure and function of the IMS Nominating Committee,
2) Specialty representation in the House of Delegates,
3) IMS Membership for Resident Physicians, and
4) Reapportionment of the House of Delegates.

The Committee's recommendations will be presented by sections to enable the House to consider each one separately.

The Committee has devoted much time and effort to studying these issues and has agreed on several recommendations. In view of the intense interest in and the complexity of one recommendation (reapportionment), it is suggested the Annual Meeting of the House of Delegates in April 1973 receive the recommendation on reapportionment as an informational item and postpone formal action on it until a regular meeting of the House of Delegates in the fall. This will permit the delegates to discuss the ramifications of the recommendation with local colleagues to assure a thorough understanding by as many IMS members as possible before it is acted upon.

IOWA MEDICAL SOCIETY NOMINATING COMMITTEE

Following a complete review of the Articles and By-Laws as they pertain to the Nominating Committee and a detailed analysis of the present function of the Nominating Committee, the Committee feels any problems which have arisen or may arise in the future are ones of communication. The Committee therefore recommended that the Board of Trustees and Judicial Council review the administrative procedures that are followed, and the District Councilors be given more assistance in carrying out their duties in relation to the Nominating Committee. Following adoption of this recommendation by the Executive Council, a document entitled "Judicial Council and Nominating Committee Timetable and Guidelines" was drafted (See Attachment #1). Adherence to the "Timetable" should serve to shore up any weaknesses in the function of the IMS Nominating Committee.

SPECIALTY REPRESENTATION IN THE HOUSE OF DELEGATES

As background for its consideration of this item, the Committee reviewed figures on:

1) The number of specialists and general practitioners in the House of Delegates for the years 1962, 1967, and 1972.*

2) An individual breakdown of the IMS House of Delegates for the same years listing the specialties among the Delegates and the Alternate Delegates.*

3) A breakdown of the IMS membership by specialties.*

The Committee members also visited with their colleagues to ascertain the general interest in specialty representation in the House of Delegates. Other factors discussed were:

1) Which specialties would have representation if such were granted since there are at least 30 recognized specialties and several subspecialties.

2) Very few states, if any, provide representation in the House of Delegates for specialty organizations.

3) In 1972 the IMS conducted a briefing session for representatives from the various specialty organizations to bring them up to date on Society activities and to provide the specialty organizations with an opportunity to discuss matters of importance. This type of meeting has been held again in 1973.

4) The IMS Committee on Legislation routinely invites a representative from each specialty organization to attend meetings of the Committee as it considers the overall legislative program of the IMS.

The Committee believes philosophical agreement and unity exist within the family of medicine and the present system of representation provides ample opportunity for all interested parties to be heard, i.e., specialty societies, county societies, individual members, etc. Therefore, the Committee recommends no change in terms of specialty society representation in the IMS House of Delegates.

MEMBERSHIP FOR RESIDENT PHYSICIANS

A special Subcommittee has been created to study and suggest recommendations regarding intern and resident representation in the IMS House of Delegates. The Subcommittee has had available information on the number and location of interns and residents in the state. It has also reviewed provisions of the IMS Articles and By-Laws recently adopted for student membership to determine if intern and resident participation would be possible through a similar provision or by using the same component student society when and if one is formed. A specific recommendation will be submitted to the House in April.

HOUSE OF DELEGATES REAPPORTIONMENT

The Committee's major deliberations have concerned House reapportionment. The Committee considered a multitude of approaches to House representation. Without going into great detail, the Committee would like to review various aspects of reapportionment which have been studied.

At its original meeting the Committee concluded that apportionment is tied in closely with redistricting. The Committee determined initially that the state should be divided into districts more closely equal in physician population. (The present 12 districts range from a low of approximately 30 physicians to a high of approximately 600 physicians.) The House of Delegates in 1969 suggested the IMS might consider redistricting following the 1970 census which required dividing the state into six somewhat equally populated congressional districts. The Committee therefore used in its consideration of redistricting a modified version of the new six congressional districts. Originally the Committee agreed the following criteria should be applied for study purposes:

1) Each component society which has at least 10 members would be allotted one delegate. Since several counties do not have 10 members, it would be necessary to determine possible combinations of counties to bring the respective combined memberships to the 10-or-above level.

2) Figures would be tabulated demonstrating the delegate apportionment on the basis of one delegate per 20 members, or major fraction thereof for each district; one per 25 members or major fraction thereof; and one per 30 members or major fraction thereof. This would be in addition to the one delegate for each component society with over 10 members.

The Committee then reviewed in some detail maps which divide the state into 6-7-8-10-11 and 12 districts. The Committee considered representation on the basis of one delegate for each component society plus one for

* (See Attachment #2.)

each 20, 25, or 30 members in the district or major fraction thereof. In this study those counties with membership under 10 physicians were amalgamated with a neighboring county. The primary objection to this approach is the need to amalgamate counties to reach a total of 10 physicians in a component society. Approximately 50 counties would have been involved.

The Committee then considered an additional alternative. Under this approach House representation would be based on one delegate for each 15 members or major fraction thereof within a district. This same formula would apply whether the state is divided into 6-7-8-10-11-12 districts or any other number. Each component society within a district would nominate a minimum of one delegate with an additional delegate nominated for each 15 members or major fraction thereof within the component society. A component society having the right to nominate more than one delegate could not nominate or elect more than its proportionate share of delegates within the district.

In an effort not to force counties to amalgamate but still assure smaller counties (to as large a degree as possible) of a delegate the Committee considered ways to have these small counties reserve the right to elect a delegate. The most feasible approach appears to be to permit a county with few physicians to join with other counties and guarantee them a delegate. This could hold true for a county with 15 members or any combination of counties with 15 or more members.

As additional background, the Committee analyzed attendance at meetings of the House of Delegates for each year since 1967. The Committee was disappointed to learn an average of approximately 30 counties were not represented at the meetings of the House of Delegates. This is especially disappointing in this era of everyone wanting to be involved and represented in organizational activity. The Committee also researched the makeup of the House of Delegates in 22 other states.

After a detailed review of all of the above options, the Committee has reached a recommendation which it feels will provide an opportunity for all component societies, both with small and large numbers of physicians, to play an active role in the future of organized medicine. The recommendation will permit existing county medical societies to maintain autonomy but will recognize the opportunity for counties with few physicians to amalgamate with an adjoining county medical society when they deem this advisable. The Committee therefore recommends the following plan as a means of reapportioning the IMS House of Delegates:

1) The present number of councilor districts (12) should be retained. However, in order to achieve a more equal proportion of members in each district, the present councilor districts should be realigned. This could be accomplished without an amendment to the Articles and By-Laws and could be achieved by a simple action of the House of Delegates. The suggested realignment of districts is illustrated in the attached map, (See Attachment #3). It is recognized that a county medical society for various reasons may want to be in a different district than the one recommended. Final geographic boundaries would be up to the House of Delegates but the Committee believes it essential that all districts be compact (contiguous) and not unduly disproportionate in doctor population.

2) Each district would be allowed to elect one delegate for each 15 members or fraction thereof in the district. In order to assure that the smaller counties have the opportunity to be represented in the House, it is further recommended that the following provisions be made:

a) Each county shall be able to elect from its membership no more than its proportionate share of the total number of delegates in the district.

b) If a county does not have within its boundaries the 15 members necessary to secure a delegate's seat, that county may combine with another county for the purposes of electing a delegate.

Under this plan, every component society or combination thereof whose membership is 15 or more shall be able to elect a delegate if it chooses to do so. In addition, each component society has the opportunity to nominate physicians to run as delegates at large.

The Committee wishes to remind the House the last section of this report is at this time intended for information only with final action to be taken at a 1973 regular meeting of the House of Delegates. Because of this fact no request for drafting appropriate amendments has been forwarded to the Committee on Articles of Incorporation and By-Laws. This could perhaps be accomplished prior to the next House meeting based on guidance from the House in April.

C. R. ASCHOFF, M.D., *Chairman*

ATTACHMENT NO. 1

Judicial Council and Nominating Committee Timetable and Guidelines

January Judicial Council Meeting—Review in detail the procedures to be followed by the Councilors in coordinating the Nominating procedures.

During January—News Bulletin to all IMS members including a list of all offices to be filled. Encourage individual physicians and county medical societies to suggest possible candidates to the District Councilor.

First week of February—Letter from the IMS Secretary to the Councilors announcing the date of the Nominating Committee meeting (last Sunday in March). District caucus must be held and names of delegate and alternate to the Nominating Committee must be submitted to the IMS no later than the end of the second week in March.

First week of February—Obtain names of those whose term on the Blue Shield Board will expire, including four names of physicians from the Blue Shield Board to be forwarded to the IMS/BS Liaison Committee to be transmitted to the Nominating Committee for election as liaison delegates.

Second week of February—IMS Headquarters to be notified by each Councilor of the date, place and time of his district caucus. IMS staff will work with Councilors in preparing and mailing caucus announcements to all delegates and alternates for all 12 districts. All caucuses must be held prior to end of the second week in March.

Second week of February—News Bulletin to all IMS members announcing dates of 12 district caucuses and date of Nominating Committee meeting including offices to be filled. District caucuses to be open to all IMS members except when in executive session.

Last two weeks of February and first two weeks of March—District caucuses to be held. District delegate and alternate delegate to the Nominating Committee to be selected. Suggested candidates to be selected. Essential to check with physicians to determine if a nominee will agree to be nominated and serve if elected.

Last week of February—Letter to IMS/BS Liaison

Committee to obtain approval of the four names for election as liaison delegates. Names will then be submitted to Nominating Committee for inclusion on final slate.

First week of March—Follow-up contact with Councilors regarding names of delegates and alternate delegates to the Nominating Committee plus listing of offices to be filled.

Second week of March—Official letter to delegates and alternate delegates announcing meeting of the Nominating Committee (last Sunday in March), including a listing of offices to be filled and appropriate IMS By-Law sections. Remind delegates and alternates of necessity to obtain prior approval, preferably in writing, from all possible nominees that they will accept nomination and serve if elected. Also a News Bulletin announcing the members of the Nominating Committee.

Last week in March—Meeting of Nominating Committee, 2:00 p.m.

Following Wednesday—News Bulletin to all members announcing slate adopted by the Nominating Committee.

ATTACHMENT NO. 2

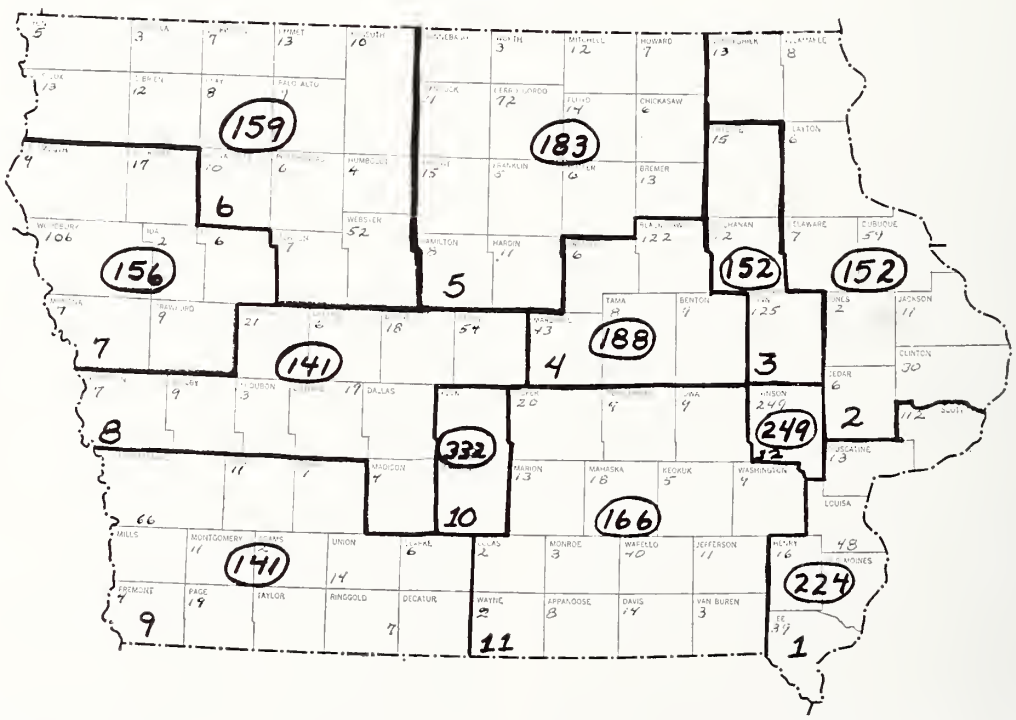
1972 HOUSE COMPOSITION

	Delegates	*Alternates*
GP	92	76
Surgery	13	15
OB-Gyn	3	4
Internal Medicine	5	9
Ophthalmology	3	2
Dermatology	3	0
Radiology	7	5
Urology	6	1
Orthopedic Surgery	2	3
Pathology	5	2
Psychiatry	2	1
Otolaryngology	0	3
Pediatrics	0	2
Anesthesiology	2	2
Cardiovascular Disease	1	0
Gastroenterology	0	1
Administrator	0	1
	144	127

BREAKDOWN OF IMS MEMBERSHIP BY SPECIALTY

Specialty	*Number*	*% of Total*
General Practice	914	41
Surgery	245	11
Internal Medicine	226	10
Radiology	104	5
Psychiatry	102	5
OB-Gyn	93	4
Anesthesiology	82	4
Pathology	81	4
Pediatrics	77	3
Otolaryngology	66	3
Ophthalmology	61	3
Orthopedic Surgery	60	3
Urology	52	2
Dermatology	34	1
Neurology	14	1
Others	32	1
D.O.s	5	0
	2,248	100

ATTACHMENT NO. 3



Circled figure is total number of members in each district. Small number in each county represents number of physicians in that county.

COMMITTEE ON INDEPENDENT LABORATORIES

The Committee has been involved in one project this year. Approval was given in October by the IMS Executive Council to a Committee recommendation that the Society endorse a regional (Iowa and Wisconsin) program for quality assurance of clinical laboratory results. This voluntary program is now being instituted by the Iowa Association of Pathologists.

The following descriptive paragraph on the program is taken from a summary which appeared in the March issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY and also as an enclosure with a recent IMS News Bulletin:

"If your office or clinic has a laboratory that performs any clinical chemistries, prothrombin times, partial thromboplastin times, or blood counts, you may want to take advantage of the Quality Control Program for 1973 organized by the Iowa Association of Pathologists. The program is designed to provide a relatively inexpensive daily control of precision and is being utilized by the majority of hospitals and pathology laboratories in the state. Monthly computer printouts are returned to each individual participant providing not only the statistical data for that participant, but also including material showing how the performance of the individual compares with all of the other participants. All participants are identified by a number only, so that confidentiality is preserved."

Activation of this private and voluntary proficiency testing program is regarded as important and worthwhile in view of 1972 state legislation passed in California and Arizona which makes it mandatory for physicians' office laboratories to be involved in this type of program.

The Committee draws attention to the various additional educational activities which are scheduled about the state through the efforts of the State Hygienic Laboratory and the Iowa Association of Pathologists.

As noted in previous reports, three representatives of the Committee form a subcommittee to provide liaison to the Iowa Society of Medical Technologists. No activity is occurring in this area at this time.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health has sought this year to aid Iowa physicians in gaining an understanding of the broad and complex Occupational Safety and Health Act (OSHA) of 1970. The law has broad implications for physicians both as employers and as medical practitioners.

Because most Iowa physicians have only sketchy knowledge of the provisions of this law, the Committee provided to each county medical society in January a "Physician's Guide to the Occupational Safety and Health Act of 1970" prepared by the AMA Council on Occupational Health. Additional copies are available.

Also, the Committee has been offered assistance by the Office of Continuing Medical Education at The University of Iowa in arranging education programs on OSHA for county medical societies. This invitation remains open to counties wishing to contact the Committee through IMS headquarters.

Preliminary effort has been made to arrange a meeting of the Committee with Mr. Robert Landes, the Iowa Industrial Commissioner, and Mr. Jerry Addy of the State Labor Department. A discussion of the medical aspects of their activities will take place.

Proposed legislation having to do with the recognition of and compensation for noise induced hearing loss has been brought to the attention of the Society and will be evaluated.

SIDNEY BRODY, M.D., *Chairman*

MD/DO LIAISON COMMITTEE

The Committee has a meeting scheduled in mid-March and any specific action taken will be submitted to the House in the form of a supplemental report.

The Chairman continues to consult with physicians and institutions at the local level who have questions about MD/DO relationships.

The current status of the IMS/ISOPS Evaluation and Enrollment Program is as follows:

Approved by the IMS Judicial Council	172
Disapproved by the IMS Judicial Council	14
Applications pending or no reply from county ...	8

J. M. RHODES, M.D., *Chairman*

MEDICAL ASSISTANTS ADVISORY COMMITTEE

The Medical Assistants Advisory Committee was not called upon to perform any specific functions or tasks during the past year. However, it does wish to take this opportunity to call to the attention of Iowa physicians the following "Code of Ethics" to which members of the Iowa Association of Medical Assistants subscribe:

"Within the scope of her duties, the medical assistant shall render to her employing physician and his patients, service to the fullest extent of her ability. She shall not reveal confidences of any patients, physicians or other members of the medical profession. She shall continually strive to improve her knowledge and her skills in order to better serve her physician employer and his patients. She shall uphold the dignity and honor of the medical profession. She shall accept the self-imposed discipline, thereof. She shall conduct herself at all times in such a manner as not to reflect any legal or ethical reproach toward her employer."

Last year, the House of Delegates meeting was again graced on Sunday by representatives of the Iowa Association of Medical Assistants who served coffee to the delegates, other physicians, and guests. The "coffee-bar" has been sponsored by the IAMA for several years and is appreciated by the Society.

The IAMA continues to prepare and distribute a membership newsletter on a quarterly basis. The IMS is pleased to assist in the financing and printing of this publication.

The Committee commends Mrs. Jeanne Green, of Davenport, for her work and service as a trustee of the American Association of Medical Assistants, a post to which she was elected in 1971.

JAMES F. BISHOP, M.D., *Chairman*

COMMITTEE ON MEDICAL MANPOWER

The Committee on Medical Manpower did not undertake any specific projects during the past year. The Committee has been kept apprised of medical manpower developments at the national level. Reports emanating from the AMA have been provided individual members.

The Society has endeavored to promote Iowa as a place to practice through communications with students, graduates, interns and residents at The Univer-

sity of Iowa College of Medicine, as well as with Iowa graduates who are completing internships and residencies elsewhere. In a new joint project of the IMS and College of Medicine, Iowa communities seeking physicians have been invited to develop special exhibits highlighting the advantages of and opportunities in their areas. These community displays are presented in the Medical Student Communications Center at the College of Medicine on a rotating basis.

The IMS continues its endorsement of the Medical Education and Community Orientation (MECO) project of the Iowa Chapter/Student American Medical Association. This is the summer job-education program designed to place freshman medical students and entering freshman students in community hospitals during vacation periods, in an effort to increase the scope of their education, and to stimulate their interest in practicing in smaller Iowa communities. The Society has sent letters to the chiefs of medical staffs of all hospitals in the state, as well as to the presidents and secretaries of county medical societies, urging support of this program. Approximately 70 students participated in the project in 1972.

The Society's Physician Placement Service serves physicians who are seeking practice locations and communities which need physicians. An "In the Public Interest" article describing the successful efforts of the Placement Service was published recently in the IMS JOURNAL.

Mention should also be made of the efforts of the IMS and the Iowa Academy of Family Physicians, in consultation with The University of Iowa College of Medicine, to obtain state funds, supplemental to the Board of Regents appropriation, to establish family practice residencies in community hospitals in Iowa, in affiliation with the College of Medicine. Officials of the Academy, who developed the proposal, and the IMS feel this use of state funds will aid considerably in developing quality family practice residency programs in community based hospitals, and in training greater numbers of family practitioners for Iowa. The Legislative Committee will report to the House in April on any specific developments in this regard.

BYRON MERKEL, M.D., *Chairman*

COMMITTEE ON MEDICINE AND RELIGION

On the recommendation of the Medicine and Religion Committee, Elisabeth K. Ross, M.D., of Chicago, presented a talk on "The Needs of the Dying Patient" at the 1972 Annual Meeting. A companion seminar session on this subject involved Reverend Russell C. Striffler, Director of Chaplaincy, St. Luke's Methodist Hospital, Cedar Rapids; David Belgum, Ph.D., Professor of Religion and Coordinator of Clinical Pastoral Education, University of Iowa; Israel Penn, M.D., Professor of Surgery, University of Colorado Medical School; Doctor Ross; and, as moderator, Paul Ferguson, M.D., who was chairman of the Medicine and Religion Committee. Mr. Arne Larson, director, AMA Department of Medicine and Religion, attended the program, and he, along with members of the Committee, had opportunity to meet with the panel members during a special luncheon.

A special invitation to this portion of the Annual Meeting program was extended to the institutional chaplains and seminary representatives in the state, and many were in attendance.

The discussions by Dr. Ross and the panel members were outstanding and were obviously a well-received and worthwhile part of the program.

To stimulate development of local programs to improve communication and understanding between the physician and the clergyman in their involvement with patients/parishioners, the Committee has requested IMS field representatives to provide specific information on medicine and religion projects to county medical society officers in their personal visits. Brochures and suggested program formats have been made available to county societies, and the Committee stands ready to assist physicians at the local level in implementing medicine and religion programs, and arranging county or regional physician/clergy meetings.

In February, the chairman of the Committee attended a regional workshop on medicine and religion sponsored by the AMA. Representatives from several states participated in the exchange of ideas and information about sponsorship of worthwhile medicine and religion programs at the county and state levels.

Representatives of the Committee have met with the in-resident psychiatrist at the three seminaries in Dubuque (Wartburg, Dubuque, Loras) to consider steps which might be taken to initiate pastoral-education programs at these institutions. It is anticipated that a special conference for physicians and clergymen in the Dubuque area will be arranged.

O. E. SENFT, M.D., *Chairman*

NATIONAL EMERGENCY MEDICAL SERVICE COMMITTEE

The Committee on National Emergency Medical Service did not have cause to meet during the past year. No specific items were referred to it for consideration.

In an effort to foster liaison and communication between the Committees on NEMS, Rural Health, and Safe Transportation, which have overlapping interests, two members from each of these committees now serve on a new IMS Committee on Community Emergency Medical Services. However, the NEMS Committee continues to maintain close liaison with departments of state government which are involved in civil defense programs, and those concerned with natural or man-made disasters.

ROBERT C. LARIMER, M.D., *Chairman*

COMMITTEE ON ONCOLOGY

One matter was referred to the Committee on Oncology this year which was subsequently reported to the IMS Executive Council. The following excerpt from the minutes of the Executive Council meeting of October 26, 1972 provides an explanation:

"Based on information provided by Gilbert Clark, M.D., chairman of the Oncology Committee, and C. W. Seibert, M.D., Waterloo, the Executive Council expressed approval of a proposed pap smear project to be conducted in Black Hawk County by the Iowa Division of the American Cancer Society, subject to final approval by and cooperation from the Black Hawk County Medical Society. This is to be a closely controlled project to determine the extent of need and the interest in pap smears among older women and women in the lower socio-economic groups."

The Society this year was pleased to submit the name of Norman K. Rinderknecht, M.D., Des Moines, to serve as an IMS representative on a Uterine Cancer

Task Force Advisory Committee of the Iowa Division of the American Cancer Society.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON ORGAN TRANSPLANTATION

The Committee has met on two occasions in the past year. Over 60 patients have been transplanted at the University of Iowa-VA Center the past three years with about half of them being transplanted in 1972. Over 70 per cent were cadaver organ donations. The Committee has considered measures that might increase the number of cadaver donors. The major effort was directed at a bill to be presented to the Iowa General Assembly to define brain death. The recommendations of the Transplant Committee were accepted by the Executive Council, and now the Legislative Committee is composing a bill patterned after the Kansas Act.

Through the efforts of the Transplant Committee chairman and the Kidney Foundation of Iowa, the Iowa legislature passed a renal disease bill. The money appropriated with this act will help to defray the expenses of patients with end-stage kidney disease for dialysis and/or transplant. The Governor's recent budget included $208,000 per year for the next two years to support the activities of the Renal Disease Commission. Part of this appropriation can be used for cadaver organ recovery.

The Congress of the United States recently passed a "landmark" bill which allows the use of Social Security trust funds for treatment of eligible patients with end-stage kidney disease. This treatment includes dialysis and transplant. The State of Iowa appropriations will be helpful in implementing this bill.

Organ recovery and preservation activities have increased during the past year. The Regional Medical Program has sponsored some of this activity, and organs have been recovered from out-of-center hospitals in Sioux City, Fort Dodge, Waterloo, and Cedar Rapids. The need for cadaver organ recoveries is quite obvious when one considers that over 70 per cent of patients on dialysis will require a cadaver organ.

The treatment of end-stage renal disease is multidisciplinary and the community is involved in helping to rehabilitate patients and to support the recovery of vital and scarce organs. The Kidney Foundation of Iowa, through its Gift of Life Program, informs the public of the need for cadaver organ donations, and how a person can donate a vital organ. The Governor was present at the Gift of Life luncheon at the time of the Annual Kidney Foundation Meeting, and was given a Recognition Award. Also attending this luncheon were 25 transplant patients and an equal number of dialysis patients.

The Transplant Committee will develop medical criteria for patients needing transplantation within the framework of the recent national legislation. The IMS membership will be kept informed of transplant activities.

R. L. LAWTON, M.D., *Chairman*

COMMITTEE ON PARAMEDICAL SERVICES

No matters have been referred to the Committee on Paramedical Services this year, and thus no meetings have been held. The Committee remains on call to evaluate those items directed to it.

Attention is called to the report of the Committee on Physicians' Assistants. Activity in this area has been significant this year. The State Board of Medical Examiners and the Governor's Advisory Committee on Physicians' Assistants have recently submitted their required report setting forth recommendations on the training and certification of these paramedical workers.

In addition, The University of Iowa College of Medicine has instituted a two-year instructional program for the physician's assistant and enrolled its first class of 10 students in September.

Dialogue with the nurses has been ongoing and the IMS Committee on Delegation of Authority was recently designated as the liaison body with the Iowa Nurses' Association and the Iowa Board of Nursing.

Youngsters interested in one of the numerous paramedical fields continue to be provided copies of the AMA booklet entitled, "Horizons Unlimited."

The Society continues to assist the Iowa Chapter, American Association of Medical Assistants, by allotting a page for its use in each issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

J. T. BAKODY, M.D., *Chairman*

COMMITTEE ON PHYSICIANS' ASSISTANTS

Although it has not been necessary to schedule a meeting of the Committee on Physicians' Assistants during the year, individual members have been kept apprised of developments relating to all aspects of the training and utilization of PA's, both at the state and national levels.

The Chairman of the IMS Committee also is Chairman of the Advisory Committee on Physicians' Assistants to the State Board of Medical Examiners. The Advisory Committee was appointed by the Governor in accordance with an Act passed by the first session of the 64th Iowa General Assembly to establish a program to permit doctors' assistants to work under a doctor's supervision.

The Advisory Committee has been concerned with matters pertaining to the education of physicians' assistants, and approval of applicants to supervise a physician's assistant; in addition, it prepared and submitted a report to the Governor and to the Iowa General Assembly on January 31, 1973, which summarized the discussions and conclusions of the Committee, and also contained specific recommendations.

In its report, the Advisory Committee noted the following:

1) The University of Iowa College of Medicine has developed the only program for the education and training of physicians' assistants in Iowa, and it has been approved by the Board of Medical Examiners.

2) Guidelines have been established for the review of requests from physicians for the utilization of assistants under the Act, i.e.,

a) That the Board grant certification to those assistants whose applications indicate graduation from an approved program for the training of Class A (primary care) physicians' assistants.

b) That criteria for judging equivalent training obtained in informal manner by applicants for positions as physicians' assistants be referred to the faculty of the Physicians' Assistants Program at the University of Iowa for their advice and counsel.

c) That any approval of a physician's assistant in this state at the present time be granted only on a temporary basis, with instruction to the applicant concerning the temporary nature of the appointment.

d) That the Board of Medical Examiners inform all approved physicians' assistants that in order to obtain continuing and permanent approval under the present law, once a national certifying examination is developed, successful completion of this examination will be required of all physicians' assistants who have been certified within the state.

3. Application forms were developed for the physician and for the physician's assistant, requesting review and registration under the Act.

4. Liaison was maintained with appropriate committees of the IMS, Iowa Society of Osteopathic Physicians and Surgeons, Iowa Nurses' Association, and Iowa Hospital Association relative to the utilization of physicians' assistants in the state and the legal implications of this development.

5. The development of certification examinations at the national level was reviewed; these will serve as equivalency testing programs for those who have not completed formal physicians' assistants training.

6. There has been an extensive review of all available data on the subject of physicians' assistants.

It was recommended to the Governor and to the General Assembly that the Advisory Committee continue its study of all matters pertinent to the education, training, certification, etc., of physicians' assistants in Iowa.

An excellent summary of the Advisory Committee's report was published in the February 1973 issue of the IMS JOURNAL in the "In the Public Interest" section. This feature is mailed regularly to all legislators and all news outlets in the state.

In a recent letter to the Advisory Committee, the President of the Iowa Medical Society reaffirmed the Society's interest in and endorsement of the physician's assistant concept. He recited the role of the IMS in actively supporting the passage of legislation in Iowa to establish a program to permit doctors' assistants to work under a doctor's supervision. He advised that the IMS has been kept apprised of the development of the PA training program at The University of Iowa, and that a progress report was presented to the Executive Council last October by A. W. Horsley, M.D., Assistant Dean, who is directing the program. Finally, President Lister advised that, at its November 1972 meeting, the AMA House of Delegates emphasized that the physician's assistant can function most safely and effectively only as an extension of, and not as a substitute for, the physician. He mentioned further AMA reaffirmation of policy setting forth the physician's moral, legal and technical responsibility for all patient care actions of an assistant in his employ.

JOHN K. MACGREGOR, M.D., *Chairman*

PRECEPTORSHIP COMMITTEE

The Preceptorship Committee of the Iowa Medical Society has maintained liaison with a similar committee of The University of Iowa College of Medicine. There has been consideration of matters pertinent to the implementation of a two-week preceptor program which students are now required to complete within the third year in medical school.

In an effort to gain an accurate impression of the effectiveness and benefits derived from the preceptorship program, special forms have been developed for use by medical students in evaluating their preceptorship experiences. All preceptors will receive copies of the new evaluation form for their information and file, so they will have an opportunity to review the educational objectives of the program. The document will receive periodic review and comment by both the IMS and faculty preceptorship committees so that necessary improvements can be made on a continuing basis.

At the present time physicians who serve as preceptors are being requested to complete an evaluation form regarding their preceptees. This form will become a part of the students' permanent academic records.

The Committee is pleased to know every effort is being made to assure a high quality and mutually beneficial educational experience for both the preceptee and preceptor. Although the Preceptorship Committee of the College of Medicine has assumed responsibility for overseeing the preceptorship program as a part of the medical school curriculum, the IMS Committee will continue to function in an advisory capacity. College of Medicine officials have indicated the IMS Committee can provide a valuable service by offering constructive comments on the preceptorship program and by assisting in resolving any problems that might arise.

The Preceptorship Committee will maintain liaison with the Iowa Chapter/SAMA and the College of Medicine with respect to the implementation and promotion of the Medical Education and Community Orientation project. MECO is a summer job-education program designed to place freshman medical students and entering freshmen in community hospitals during their vacation periods in an effort to increase the scope of their education and to stimulate their interest in practicing in smaller communities.

L. D. CARAWAY, M.D., *Chairman*

COMMITTEE ON QUACKERY

The Committee on Quackery has been kept apprised of developments at both the state and national levels with respect to all aspects of combating medical quackery. Primary attention has been focused on problems relating to the hazard and practice of chiropractic, since the medical profession, including the IMS, is officially on record as opposing chiropractic as "an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease."

The Committee was disappointed that the 92nd Congress approved an amendment to the Social Security Act to permit chiropractic services to be covered under Medicare. However, the law is ambiguous, and it should be underscored that services will be restricted to "treatment by means of manual manipulation of the spine (to correct a "subluxation" demonstrated by X-ray to exist) which the chiropractor is legally authorized to perform by the state or jurisdiction in which treatment is provided"; further, that payment will be limited to those chiropractors who meet educational and training standards set forth by the Secretary of HEW.

The Committee chairman maintains contact with the Legislative Committee, and the legislative activities of the chiropractic organizations are watched with interest and concern.

The members of the Committee have been provided a copy of a report of a study committee to the Wisconsin Governor's Health Planning and Policy Task Force. The Study Committee recommends, among other things, the implementation of a program to educate all citizens regarding the nature of chiropractic, its lack of scientific validity, and the potential hazards associated with its use.

A member of the Committee, C. H. Denser, M.D., Des Moines, is serving on the AMA Committee on Quackery, and he is diligent about keeping both the IMS and AMA apprised of mutually important and pertinent activities in the area of quackery.

In response to an inquiry from the press late in the year, the President of the Society issued a statement on acupuncture in which he emphasized that it, like any other unproven method of treatment, demands scientific validation; further, at this time, the scientific community believes there is no evidence to support most of the therapeutic claims that are being made for acupuncture. It was also pointed out that the belief acupuncture may be efficacious as an anesthetic also needs to be substantiated. Attention was called to a statement of the American Society of Anesthesiologists, as follows: "The safety of American medicine has been built on the scientific evaluation of each technique before it becomes a widely accepted concept of medical practice. The premature use of acupuncture in the United States at this time departs from this traditional approach."

W. R. WHITMORE, M.D., *Chairman*

COMMITTEE ON RURAL HEALTH

The chairman of the Rural Health Committee represented the Iowa Medical Society at the National Conference on Rural Health held in San Francisco last March, and participated in a special program for state rural health committee chairmen.

The chairman also represents the Rural Health Committee on the Society's Committee on Delivery of Health Services, which has an overlapping interest in problems and projects relating to insuring the availability and acceptability of health care in rural areas.

The Committee chairman will be one of two IMS representatives on a committee to develop scientific plans and arrangements for a series of regional meetings to be conducted throughout the state to discuss long-range health plans for various areas in the state. A report titled "A Proposed Organizational Structure for Providing Health Services and Medical Care in the State of Iowa" will be used as a basis for discussion at the meetings, to which physicians, allied health personnel and community leaders will be invited.

MAX E. OLSEN, M.D., *Chairman*

COMMITTEE ON SPORTS MEDICINE

After its sponsorship of the successful one-day Conference on the Medical Aspects of Sports on March 30, 1972, the Committee on Sports Medicine has had a relatively uneventful year. Approximately 300 coaches, trainers and physicians attended this event in Des Moines. The Iowa High School Athletic Association was a co-sponsor of the conference.

More recently, however, the Committee did participate to some extent in a December Mid-West Chapter Symposium and Workshop of the American College of Sports Medicine in Iowa City. Theme of this program was "New Directions in Sports Medicine." On the recommendation of the Committee and with the support of the Scanlon Medical Foundation/Iowa Medical Society, the medical profession sponsored one of the workshop speakers.

Note is also made of the successful North Iowa Sports Medicine Symposium which was held August 12 in Mason City. The Cerro Gordo County Medical Society was one of the organizations which arranged this meeting.

The Committee continues to follow the research which is being done to find optimal methods for assuring safe participatory weight levels for high school wrestlers. Charles M. Tipton, Ph.D., University of Iowa, has been the principal investigator, and the Committee is following his work. Several of his studies have been published this year, and both Minnesota and Nebraska are utilizing his findings in their experimentation.

Dr. Tipton is continuing to measure and analyze selected Iowa high school wrestlers. His emphasis at this time is on the development of urinary profiles. He is postulating this may represent an effective screening device in assessing the competitive acceptability of the wrestler. He is examining urinary changes which occur prior to weigh-in, particularly when associated with dehydration. He is also examining what happens to the urinary system during rehydration following the weigh-in.

The Society's position favoring mandatory trial use by the Iowa High School Athletic Association of the weight determination procedures remains in abeyance.

The Society continues to supply informational material in response to requests which are received. Particularly popular has been the nutritional booklet devised by Pauline Mairs of Iowa State University in cooperation with the Committee and the Iowa High School Athletic Association.

R. W. ANDERSON, M.D., *Chairman*

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

No specific matters have been referred to the Committee on Voluntary Health Agencies and thus no meetings of the Committee have been held.

The Society continues to work with the various voluntary agencies in different projects. For example the 1972 Iowa State Fair Hall of Health project, which is coordinated by the Iowa Medical Society for the Iowa Health Council, included the education exhibits of several voluntary agencies.

The Society has recently cooperated extensively with the Kidney Foundation of Iowa in the presentation of a renal disease symposium in the February issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. This presentation was timed to precede a series of physician conferences on renal disease to be held this spring around the state.

It is somewhat traditional in this brief report to commend the effective and dedicated service which many Iowa physicians provide to the local, state and national components of the various voluntary health organizations. This medical expertise is invaluable to the operation of these organizations.

A file of reference material on the programs and activities of the various voluntary organizations is maintained at IMS Headquarters. Information from this file is provided to persons making inquiry. Of particular value in determining the purpose, organization, financing and programming of any voluntary group is the AMA Directory of National Voluntary Health Organizations.

C. E. SCHROCK, M.D., *Chairman*

WOMAN'S AUXILIARY ADVISORY COMMITTEE

Several members of the Woman's Auxiliary to the Iowa Medical Society had an opportunity to attend the 50th Anniversary Convention of the Woman's Auxiliary

to the American Medical Association in San Francisco. At the convention they could sense the commitment of the Auxiliary to the health problems of the young, the old, the mentally ill, the migrant worker and the whole American society.

Physicians' wives are adopting a new image that stresses community involvement. They are well educated and more aware of things that happen outside the limited sphere of their homes—and they recognize that the time has come for them to make more of a commitment to some of the health problems in American society.

Iowa has once again been recognized at the national level through the appointment of two of its members. Mrs. Howard G. Ellis is the National Auxiliary's Health Services chairman, and Mrs. Max E. Olsen is a member of the WA-AMA Board of Directors. Mrs. Olsen is also the liaison officer to WA-SAMA.

The Auxiliary's Mental Health Committee concentrated on the field of hyperactive children and their problems and causes as one of the many fields of research this year.

The Auxiliary's Health-Education Loan Fund has been called upon this past year for loans to students in approved schools of nursing, technology and paramedical therapies. In 1972 the fund totaled $28,072.90, with $22,249.71 on loan. There are now six students in school using HELF, and there are 15 graduates paying on loans.

The Auxiliary's AMA-ERF Committee raises funds for the support of medical schools and medical research. Since 1951, when AMA-ERF became one of the Auxiliary projects, it has on a national basis, contributed more than five million dollars to aid medical schools and to provide loan funds to medical students, interns and residents.

This last year in Iowa it contributed $9,730.20, an increase of 144 per cent over the previous year. This contribution averaged $8.27 per member. It is trying to increase this amount to at least $10 per member. AMA-ERF is entirely dependent on contributions from our physicians, the Woman's Auxiliary, and industry in general.

The State Auxiliary's Legislative Committee makes every effort to keep its members informed on pending health legislation, in cooperation with the IMS Committee on Legislation. The State Auxiliary again sponsored a Continental Brunch for the wives of the Iowa legislators and executive officers. This program, approved by the IMS, has always been health-related and the excellent attendance attests to its popularity.

Among its community health projects the Auxiliary continues presenting its Volunteer Health Service Award which has proved to be an excellent community public relations project. This award recognizes a woman, nominated by a county auxiliary, for outstanding volunteer service in the health field. The state award winner is recognized each year at the Auxiliary's Annual Meeting. County auxiliaries are also cooperating with the Iowa Easter Seal Society in helping to sell handcraft items made by homebound handicapped persons. This is an annual volunteer service project for the participating county auxiliaries.

Other committees have been working on their particular assignments for the year in ecology and rural health, children and youth, safety and disaster preparedness. Their projects have been concerned with drug abuse, nutrition, venereal disease, preschool vision and hearing programs, etc.

The Woman's Auxiliary News has taken on a new format this past year. It is a useful means of communication serving both state and county auxiliaries. It is distributed to all the members each month.

The International Health Committee has been very active assisting Yucatan, Iowa's sister state in Central America, in obtaining medical supplies and medicine. County auxiliaries throughout the state have collected medical and surgical supplies for use in Yucatan hospitals.

The Health Manpower Committee has encouraged the county auxiliaries to hold a Health Career Day for high school students. The Committee continues its efforts in the recruitment of new members of the health team through Health Careers and Future Nurse Clubs in junior and senior high schools. Many of these clubs are under the direct sponsorship of county auxiliaries and others depend on auxiliary members for their programs.

Increasing the membership is every member's responsibility. County medical societies are urged to support and encourage organized auxiliaries, and in smaller counties to urge doctors' wives to become members-at-large.

The Auxiliary's Advisory Committee takes pride in the accomplishments noted in this report. We commend the members for their cooperation and assistance to the medical societies at both the state and local levels. Because it is obvious the auxilians share the aims and principles of the medical societies they have been entrusted with increased responsibilities.

R. H. FLOCKS, M.D., *Chairman*

(This concludes the material published in the HANDBOOK FOR THE HOUSE OF DELEGATES.)

Supplemental Reports

BOARD OF TRUSTEES

SECTION I—GENERAL ACTIVITIES

Presented by R. L. Wicks, M.D.,
Chairman, Board of Trustees

(Referred to the Reference Committee on Reports of Officers.)

As Chairman of the Board of Trustees, it is my privilege to present this Supplemental Report to you, representing the other seven officers on the Board—Jerry Paulson and Jim Bishop, Trustees; Kenneth Lister, President; Rubin Flocks, President-Elect; Erling Larson, Vice President; Vern Schlaser, Secretary; and Tom Burcham, Treasurer. We have met together 14 times in regular session during the past 12 months, and we have conferred innumerable times informally, and via telephone conferences. We have directed our efforts to conduct the business affairs of the Iowa Medical Society in the best interest of the membership, and to guide the general activities of the Society, consistent with the actions of the House of Delegates.

One of the major decisions of the 1972 House of Delegates was to authorize the separation of the business portion of the Annual Meeting from the scientific sessions. In accordance with this action, a bold step was

taken last summer when the Board of Trustees, on recommendation of Dr. Lister, elected to hold the 1973 Annual Scientific Program outside the borders of Iowa —and the continental United States. The Paradise Island Hotel, located in Nassau, the Bahamas, was selected as the meeting site.

As anyone who attended will tell you, the scientific program presented was truly outstanding, with three full mornings of lectures and seminars, approved for 11½ hours of elective credit by the American Academy of Family Physicians. The surroundings and facilities of the Paradise Island Hotel were beautiful, and the climate was a welcome reprieve from Iowa's late winter weather.

It appears that financially the meeting will "breakeven."

A personal tragedy, the accidental death of Dr. George Bristow of Osceola, and serious injuries to his wife, was a crushing blow to those of us who attended the meeting and to his many friends at home, to say nothing of the impact on the Bristow family. It was an unfortunate and senseless accident of the kind that, unfortunately, happens every day, anywhere—and Mrs. Bristow and her two sons have our heartfelt sympathy.

Consistent with amendments to the Articles of Incorporation & By-Laws, which were approved last year, the Board, in consultation with the President, will select the site and dates for the 1974 Scientific Session. Dr. Flocks, who will be installed as President on Monday, is desirous of arranging the program in Iowa City, and if his preliminary plans are any indication, it will provide the physicians of Iowa with a unique educational opportunity—along with some enjoyable social diversions.

The schedule for this meeting of the House of Delegates—the first to be held apart from any scientific functions—has been arranged so as to provide adequate opportunity for discussion and debate, even though it is hoped all of the business can be completed in approximately 2 or 2½ days of actual sessions. If the reference committees are able to complete their hearings and finish their reports on Sunday, staff is prepared to work all night on Sunday, if necessary, so the House can reconvene for its final session early on Monday.

We anticipate no problems with this schedule, and have confirmed similar arrangements for a regular meeting of the House next fall.

As has been true in medicine so many times during the past 20 years, we have taken part in and observed events that will have a profound impact on the practice of medicine in Iowa, and upon the medical profession—the major of these being HMO enabling legislation, initial planning for the creation of Professional Standards Review Organizations (PSRO), rulings of the State Insurance Commissioner relating to provisions of Blue Shield UCR contracts; the issue of a Supreme Court decision legalizing abortion. All of these important developments will be discussed with you later this afternoon.

In recent months, we have witnessed the "expiration" of two active health planning organizations in the state—the Health Planning Council of Iowa, a voluntary organization whose creation was spearheaded by the IMS several years ago, and the Iowa Regional Medical Program, a federal program which in recent years has been engaged in funding health care delivery projects, and educational and research programs.

HPCI was the first organization in the state to focus the public's attention on the need for local and areawide health planning, not only by medical and allied health personnel, but by community leaders as well. HPCI was single-handedly responsible for stimulating and assisting in the development of some 18 areawide health planning agencies. The organization functioned well and accomplished the objectives it originally set for itself. Special recognition should be given to Dr. Homer Skinner, who not only was active in forming HPCI, but, as the Society's official representative on the Board of Directors, served as President for the first five years of its existence.

The activities of the Iowa Regional Medical Program are to be terminated by June 30, 1973, but it is anticipated that a few projects might be granted an extension to February 15, 1974. In response to an inquiry from IRMP staff, the Medical Society has indicated it would not object to RMP staff exploring the feasibility of implementing a proposed University-based Health Services Consultation Program in Iowa City, to carry out educational and other activities originally envisioned by RMP. Dr. John Sunderbruch represents the IMS on the Iowa Regional Advisory Group and is a member of the Executive Committee. He keeps the Board of Trustees and Executive Council well apprised of RMP developments and will continue to do so.

The abolishment of HPCI and IRMP brings the State Office for Comprehensive Planning to the forefront in health planning activities, especially in light of certificate of need legislation, and we are quite aware of the importance of maintaining strong and active physician participation in this governmental body. Dr. Sunderbruch and Dr. Donald Soll represent the IMS on the OCHP Advisory Council, along with other physicians from the College of Medicine and the Department of Health.

We have continued to strengthen our relations and liaison with the College of Medicine this past year. Dr. John Eckstein, Dean of the College of Medicine, is frequently invited to meetings of the Executive Council. The officers of the Society, as well as appropriate committees, work closely with Dr. Eckstein and other deans and faculty members at the College in various programs.

One of our most important joint efforts—along with the Iowa Academy of Family Physicians—is to obtain state funding through legislative action to establish family practice residency programs in various community hospitals in the state. The Academy of Family Physicians is to be especially commended for its efforts in spearheading this legislative proposal.

We have worked closely with Dr. Richard Caplan, Assistant Dean for Continuing Medical Education at the College, in developing and implementing a joint random-sample survey to determine ways in which Iowa physicians are now involved in continuing medical education activities, and what their needs and desires are in this regard. The responses to the survey questionnaires are now being tabulated, and the results will be helpful to both the Society and the College of Medicine in developing future continuing medical education programs.

We are also a co-sponsor of a series of six workshops on medical care evaluation programs, which have been arranged and conducted through Dr. Caplan's office. These workshops have been well attended, and are designed to present a rationale and a process for conducting quality of care assessment studies in Iowa's hospitals.

Next fall, on recommendation of the Society's Committee on Delivery of Health Services, and approval of the Executive Council, the Society will cooperate with the College of Medicine and the Office for Comprehensive Health Planning in arranging and sponsoring a third series of regional meetings for both medical and allied health personnel, and community leaders. The purpose of these sessions is to discuss long-range health care delivery plans for various areas in the state, based on a report titled "A Proposed Organizational Structure for Providing Health Services and Medical Care in the State of Iowa." The report, which was prepared by Dr. John MacQueen, Associate Dean at the College of Medicine, and Dr. Eber Eldridge, Professor of Economics at Iowa State University, will be used as a basis for discussion only.

It is significant and appreciated that the members of the faculty are taking the time to arrange meetings with doctors in their home communities.

The officers of the IMS, including those on the Executive Council, have been kept apprised of model programs that have been instituted by the College of Medicine—specifically, the Family Practice Rural Health Center at Oakdale, and the Community Health Center at Muscatine. Needless to say, the position of the Medical Society with respect to traditional methods of delivery of health care have been kept well in mind as these programs have been developed. In addition, Dr. A. W. Horsley, Assistant Dean for Allied Health Programs, has reported to the Council and appropriate committees of the Society on the establishment of a new Physician's Assistant Training Program at the University.

Along with our natural ties to the College of Medicine, the officers and committees of the Society also endeavor to enhance our relations with allied health organizations. Although we may not always see "eye-to-eye," we do communicate with each other and have ample opportunity to discuss our agreements and differences. For instance, the Society's Committee on Interprofessional Relations meets regularly with a similar committee of the Iowa Pharmaceutical Association, and some knotty problems have been resolved at the committee level.

We are also pleased that a special Physician-Nurse Liaison Committee has been formed, which has met three times during the past year. Again, these formal meetings between representatives of the IMS and officials of the Iowa Nurses' Association and Board of Nursing do much to alleviate misunderstandings and avoid professional problems and pitfalls.

Even the architects are getting together with us, and it is anticipated that a set of guidelines for use by physicians, architects, hospital administrators, and hospital boards will soon be available to assist them in properly planning for any hospital or health facility construction project.

Last fall, member organizations of the Iowa Health Council—including the Medical, Dental, Pharmaceutical, Nursing, Hospital, Osteopath, Podiatry, Nursing Home, and Veterinary Associations sponsored a special conference on health care and consumerism. It was an excellent program, with participation by representatives from the legislature, press and AMA. As is usually the case, the program was actually put together and coordinated by the Medical Society.

The "nuts and bolts" work of the Society is carried out by 53 standing and special committees which are manned by over 300 physicians, including many of you. Most of them are extremely active, while some serve only on a "stand-by" basis, ready to take on any problem or project which might be referred to them. A month or so ago, each delegate received a 100-page handbook which contains reports summarizing the activities and recommendations of these committees. Some of you may not have had time to read these reports. If not, I urge you to do so in order to gain a good understanding and knowledge of the broad scope and complexity of medicine's problems, as well as the programs that are being carried out in the interest of the profession and the public.

It has become a custom for the three Trustees to share responsibility for preparing and presenting the Board's Supplemental Report to the House, and it is now my pleasure to call upon my colleagues.

First, Dr. Jerry Paulson will discuss the Society's financial situation with you. Then, Dr. Jim Bishop will comment on IMS/Blue Shield relations, and he, in turn, will introduce the Chairman of the Blue Shield Board of Directors who will present a more detailed report on Blue Shield matters.

SECTION II—REPORT ON FINANCES

J. F. Paulson, M.D., Trustee

(Referred to Reference Committee on Reports of Officers.)

The Board of Trustees continues to function under a fiscal policy established by the House in 1968. The 1968 House increased the dues $25 to $150 per year effective January 1, 1969; agreed to continue the accelerated pay-off schedule on the building and recommended continued ownership of the property adjacent to the headquarters office. Final payment on the headquarters office occurred during 1972. Total investment in fixed assets is well over $400,000 and is now totally debt free. The actual market value of the property is well in excess of this figure. The Society should be proud of its foresight in purchasing the building site and constructing a most functional headquarters office which is of great benefit to the physicians of Iowa and other related individuals and organizations.

The financial statements included in the Handbook show an excess of expenses over income of more than $33,000 for the calendar year 1972. This deficit preceded by a $38,000 deficit in 1971 presents a most unfavorable fiscal picture. Since the building mortgage is now retired the budget approved for 1973 is substantially in balance. However, there is no provision for depreciation of the Society's property and no reserves other than fixed assets.

The Board has expressed to the House its distaste with operating at a deficit, especially on a continuing basis. The Board has implemented several adjustments in expenses without attempting to curtail the Society's programs. The Board is submitting to the House a copy of the 1973 budget as approved by the Board. In approving the budget the Board altered the reimbursement formula for out-of-state travel particularly as it relates to AMA and clinical meetings. Other modifications have been adopted where indicated. We encourage each delegate to give a thorough study to the Society's present financial situation.

The JOURNAL OF THE IOWA MEDICAL SOCIETY continues as the Society's official publication. Its double worth as an educational vehicle and as a historical chronicle of Society activities is regarded as significant by your officers. In a survey taken at the 1972 session of the House of Delegates 83 per cent of the respondents said they read the JOURNAL regularly and 17 per cent answered they read it occasionally.

Maximum effort has been exerted again this year to keep the JOURNAL's fiscal status in line. We are pleased to report a satisfactory picture. In 1969 the JOURNAL experienced a deficit of $21,000. In 1971 the deficit was reduced to slightly under $15,000. The deficit this year is $14,896.98. Increased production costs have made this an even more challenging effort.

It is the belief of the JOURNAL editors that Iowa physicians are best served by the presentation of three or four short scientific papers each month. Combined with these papers are various regular features that attempt also to be concise and informative. Several recent issues have been devoted to a single subject area and this has drawn some favorable reaction. For example, the February issue was developed cooperatively with the Kidney Foundation of Iowa, and the May issue will be devoted to cancer.

Marion E. Alberts, M.D., Des Moines, has completed his second year as Scientific Editor, and we are grateful to him for his efforts in behalf of the JOURNAL.

IMS members are invited to express themselves in the JOURNAL. Manuscripts, editorials, letters to the editor, etc., are welcomed and are published whenever possible.

One problem that persists is the number of eligible non-members. This figure has increased each year for the past several years and now totals more than 200 physicians who have elected not to join the Iowa Medical Society. Dues from these physicians would greatly improve the Society's financial base although the Board feels it even more important that these physicians be added to the unified strength of the Medical Society at this most crucial time in its history. The Board in cooperation with the Judicial Council is giving special attention to Society membership and hopes that 1973 will bring to the Society the active participation of most of the eligible non-members.

As the delegates review the Society's expenses it will be apparent that major expense items are: (1) salaries; (2) travel (officer and employee); (3) committee functions (including legislative); (4) taxes, and (5) JOURNAL. Even as the Society's expenses increase the Board is acutely aware of the many activities which could receive more attention and involvement if finances and staff were available. The Board has negotiated with officials of Blue Shield, the Iowa Foundation for Medical Care and the Scanlon Medical Foundation to refine formal agreements that will reimburse the Iowa Medical Society for services which too often in the past have been rendered without cost to these organizations. Although these agreements will provide some financial assistance they will not, or are they intended to, solve the long range financial problems of the Iowa Medical Society.

The Board of Trustees, after studying all aspects of the Society's finances—present and future—respectfully suggests that no action be taken on the financial report at this time; further, that the Reference Committee that receives this report be continued and serve in the same capacity at the regular session of the IMS House of Delegates to be held in the fall of 1973. This will permit the Reference Committee to have the benefit of the hearings that will occur during this session, and to make further investigation during the interim and present a final report next fall. The Board strongly urges the members of the House of Delegates also to take special interest in this matter and to discuss with their conferees the contents of the budget (Exhibit A) included in the packet and all other information available. An action by the House of Delegates in the fall will occur in time for the setting of the dues for the year 1974.

EXHIBIT A

SUBJECT: 1972 Financial Review and 1973 Budget Proposal

INCOME

Dues—State Society:

Dues for 1973 are set at $150 per member. Dues income continued its decline in 1972. Dues paying members are down 26 in 1972 from 1971 and down 114 members from the year 1966. Total dues paying members as of the end of November 1972 number 2,056. The 1973 budget is based on 2,100 members.

Proposed budget for 1973—$315,000

Interest on Investments:

Represents short term investment of surplus funds available from dues income the first of each year but not required for expenses until later in the year. Anticipate very little income in 1973 since a large amount of 1973 dues income is being used to cover 1972 expenses.

Proposed budget for 1973—$500

Miscellaneous Income:

Income received for services in connection with information provided relative to IMS members such as membership lists and adressing envelopes.

Proposed budget for 1973—$500

AMA Collection Commission:

AMA reimbursement to the IMS for collecting and forwarding AMA dues.

Proposed budget for 1973—$2,000

Total Proposed Income Budget for 1973

Dues—State Society	$315,000
Interest on Investments	500
Miscellaneous Income	500
AMA Collection Commission	2,000
	$318,000

EXPENSES

Annual Scientific Session:

Main costs will be transportation expense of speakers and staff. This will be in part offset by small amount of overage for each person attending and some contributions from former exhibitors. (1970—loss of $1,719.59) (1971—loss of $4,140.77) (1972—loss of $6,804.19)

Proposed budget for 1973—$8,000

Council Expense:

Travel and meal costs for meetings of Executive Council and Judicial Council. (1970—$3,290.67) (1971—$2,727.39) (1972—$2,817.85)

Proposed budget for 1973—$3,000

County Society Services:

This account has been charged with costs of regional meetings or a fall conference. Membership billing services of over $3,000 are included in this account. Large expense in 1971 was due to printing of Articles of Incorporation and By-Laws. (1970—$2,333.39) (1971—$5,733.33) (1972—$3,618.64)

Proposed budget for 1973—$4,000

Depreciation Expense:

This account has been adjusted yearly to reflect the principal payments on the building mortgage which is now completely retired. The total investment in land, building, furniture and equipment is approximately $421,000. No depreciation funds have actually been set aside in reserves.

Proposed budget for 1973—$.00

Dues and Subscriptions:

IMS membership in business and professional organizations and subscriptions to various publications. 1972 expenses include North Central Conference $300; Better Business Bureau $240; Chambers of Commerce $190; Iowa Health Council $300; Des Moines Club $385. (1970—$2,387.50) (1971—$2,107.50) (1972—$2,180.50)

Proposed budget for 1973—$2,200

Employee Pension, Disability and Health Programs:

New pension program implemented in 1971. Two covered employees terminated in 1972 and one additional will be added in 1973. Employee shares BC-BS premium and one-half of disability costs. Society pays entire cost of group life and employee contributes 2% of salary toward pension program. IMS costs in 1972 include: BC-BS $3,262.50; Disability $674.71; Life $1,515.48; Pension $10,000. (1970—$8,030.38) (1971—$21,845.39) (1972—$15,444.38)

Proposed budget for 1973—$16,000

Field Service:

The IMS-Blue Shield Field Service Program effective May 1968 now involves 8 persons. This account includes the IMS portion of car leasing and travel expenses for all 8 persons involved. (1970—$13,541.53) (1971—$16,295.37) (1972—$15,104.17)

Proposed budget for 1973—$16,000

General Administrative Expense:

Includes routine expenses not properly chargeable to other accounts. Largest two items are annual audit and delivery service. (1970—$1,839.06) (1971—$2,546.59) (1972—$2,967.74)

Proposed budget for 1973—$3,000

House of Delegates:

This will be the first year that the House of Delegates will be held separate from the Scientific Meeting. The 1973 budget anticipates two meetings of the House.

Proposed budget for 1973—$6,000

Insurance:

Multi-Peril $726; Accident policy for Society members and staff traveling on Society business $1,558; Boiler and Machinery $325; Workmen's Compensation $200. (1970—$2,758.27) (1971—$2,799.35) (1972—$2,944.82)

Proposed budget for 1973—$3,000

Interest Expense:

Has reflected the interest expenses on building mortgage. Building mortgage was paid off in 1972. (1970—$4,455.75) (1971—$2,233.21) (1972—$568.61)

Proposed budget for 1973—$.00

Journal:

For several years JOURNAL income and expenses have both decreased. This trend has continued in 1972 as is reflected below:

	1968	1969	1970	1971	1972
Journal Income	$36,942.85	$35,134.25	$30,395.48	$31,053.57	$27,774.54
Journal Expenses	54,173.20	56,605.98	48,608.16	45,784.44	42,671.52
Net Loss	$17,230.35	$21,471.73	$18,212.68	$14,730.87	$14,896.98

The budget figure is established on the same basis as the JOURNAL subscription rate although the actual deficit is very likely to be several thousand in excess of budget.

Proposed budget for 1973—$10,500

Legal Services:

General legal services—does not include legislative services. (1970—$11,075.00) (1971—$9,650.00) (1972—$6,370.00)

Proposed budget for 1973—$8,400

Lights, Gas & Water:

Utility expenses. (1970—$5,005.62) (1971—$6,263.85) (1972—$6,137.63)

Proposed budget for 1973—$6,000

Office Stationery and Supplies:

Self-explanatory. (1970—$6,527.24) (1971—$6,481.09) (1972—$6,203.16)

Proposed budget for 1973—$6,600

Postage:

Self-explanatory. (1970—$5,550.63) (1971—$5,689.73) (1972—$7,566.99)

Proposed budget for 1973—$6,600

Repairs and Maintenance:

Reflects building maintenance service, supplies, snow removal, ground maintenance and Honeywell maintenance and boiler contract of over $2,000. (1970—$6,843.60) (1971—$7,230.90) (1972—$7,995.55)

Proposed budget for 1973—$9,000

Salaries:

Credited against this account are certain JOURNAL salaries, Blue Shield reimbursement, specialty services. 1973 budget anticipates arrangements with Iowa Foundation for Medical Care and Scanlon Medical Foundation. (1970—$99,673.38) (1971—$106,599.33) (1972—$116,170.86)

Proposed budget for 1973—$118,800

Service Contracts—Machines:

Yearly service contracts on typewriters and other office equipment. (1970—$979.71) (1971—$1,104.33) (1972—$1,440.33)

Proposed budget for 1973—$1,440

Taxes—Personal and Property:

(1970—$13,271.95) (1971—$14,741.24) (1972—$12,885.82)

Proposed budget for 1973—$14,400

Taxes—Social Security and Unemployment:

1973 base and tax rate will both increase. The rate will be 5.8% on the first $10,800. State and federal unemployment taxes are also included in this account. (1970—$4,924.74) (1971—$5,262.19) (1972—$6,157.69)

Proposed budget for 1973—$7,400

Telephone and Telegraph:

Includes in-state WATS line. (1970—$7,366.97) (1971—$8,754.13) (1972—$8,499.50)

Proposed budget for 1973—$8,400

Travel—Officer:

Primarily travel to AMA Annual (New York) and Interim Meeting (Anaheim) plus some miscellaneous travel. (1970—$11,698.50) (1971—$13,346.60) (1972—$14,163.23)

Proposed budget for 1973—$12,000

Travel—Salaried Employees:

Travel for IMS staff except those involved in Joint IMS-BS Field Program. (1970—$9,266.07) (1971—$13,283.46) (1972—$13,469.61)

Proposed budget for 1973—$12,000

Trustee Expense:

All travel for Trustees plus the Recognition Dinner for Past Presidents and the annual Christmas Party. (1970—$4,317.39) (1971—$4,648.26) (1972—$4,587.21)

Proposed budget for 1973—$3,000

Woman's Auxiliary:

Miscellaneous projects and selected travel of Auxiliary. Staff wages for Auxiliary are also reflected in this account. (1970—$1,180.24) (1971—$3,225.81) (1972—$5,143.10)

Proposed budget for 1973—$4,800

COMMITTEE EXPENSES

Grievance:

Travel and dinner costs for committee meetings. Recommend that this expense be reported under "Other Committees" in view of the small expenditure each year for several years. (1970—$355.77) (1971—$369.26) (1972—$716.46)

Proposed budget for 1973—$.00

Legislative:

1972 expenses include: Legal $5,762.70; IMPAC $3,289.10; Washington trip $1,053.27. (1970—$31,985.37) (1971—$21,799.67) (1972—$15,328.66)

Proposed budget for 1973—$15,000

Medical Service:

This account reflects the cost of the IMS Roster. No roster was printed in 1972 but one is planned during 1973. Includes expenses for Subcommittee on Medical Review. (1970—$2,196.15) (1971—$6,128.02) (1972—$1,536.62)

Proposed budget for 1973—$3,200

Public Relations:

During the past few years expense sharing with other organizations has reduced costs in this budget item. (1970—$1,966.76) (1971—$1,243.68) (1972—$1,106.23)

Proposed budget for 1973—$1,200

State Departments:

Travel and meal expenses in connection with the committee and its subcommittees. (1970—$1,062.34) (1971—$1,262.74) (1972—$1,067.40)

Proposed budget for 1973—$1,200

Other Committees:

All committee expense not charged to a separate item. (1970—$5,342.40) (1971—$6,554.36) (1972—$6,220.01)

Proposed budget for 1973—$4,800

TOTAL PROPOSED EXPENSE BUDGET FOR 1973

Annual Scientific Session	$ 8,000
Council Expense	3,000
County Society Services	4,000
Dues and Subscriptions	2,200
Employee Benefit Programs	16,000
Field Service	16,000
General Administrative Expense	3,000
House of Delegates	6,000
Insurance	3,000
Journal	10,500
Legal Services	8,400
Lights, Gas and Water	6,000
Office Stationery and Supplies	6,600
Postage	6,600
Repairs and Maintenance	9,000
Salaries	118,800
Service Contracts—Machines	1,440
Taxes—Personal and Property	14,400
Taxes—Social Security and Unemployment	7,400
Telephone and Telegraph	8,400
Travel—Officer	12,000
Travel—Salaried Employees	12,000
Trustee Expense	3,000
Woman's Auxiliary	4,800
Committee Expense	25,400
	$315,940
Proposed 1973 Income	$318,000
Proposed 1973 Expense	315,940
Net Income	$ 2,060

The JOURNAL budget based on subscription price will not fully underwrite the JOURNAL cost; therefore the budget rather than representing a small excess of income over expense may in fact be just the reverse.

SECTION III—BLUE SHIELD

J. F. Bishop, M.D., Trustee

(Referred to the Reference Committee on Insurance and Medical Service.)

For the past several years, at the request of the House of Delegates, the Board of Trustees has assumed basic responsibility for liaison with Blue Shield. The Board has reported each year in some detail to the House of Delegates on the various programs administered by Blue Shield, both private and governmental. We should all recognize the vital role played by Blue Shield in the financing of health care in this state. Blue Shield's private business numbers more than one million Iowans. When you add to that total those persons eligible for Medicare, Medicaid and CHAMPUS, Blue Shield is in one manner or another directly concerned and involved with more than half of the Iowa population.

A unique feature which has grown out of this relationship is the joint field program of the Iowa Medical Society and Blue Shield. During 1973, the joint field program will complete its fifth year of operation. From all indications, the program has been mutually beneficial and has offered services to both organizations that would not have been otherwise possible. Recently, under a consolidation of Blue Cross-Blue Shield administrative services, a Division on Provider Relations was created. This Division should result in an even better understanding of the myriad of problems faced by physicians and hospitals and a closer cooperation between these entities.

Over the years the Blue Shield stewardship report to the House has been presented in varying ways. On occasion the Board of Trustees has felt that elected officials of Blue Shield should have an opportunity to formally address the House of Delegates. This has not been done since 1970 but we feel now is the time for the members of the House of Delegates to hear directly from a Blue Shield spokesman. It is therefore my pleasure to present to the House of Delegates, S. P. Leinbach, M.D., Chairman of the Blue Shield Board of Directors. Doctor Leinbach's service to both Blue Shield and the Iowa Medical Society is known and appreciated by this House of Delegates. It is a distinct pleasure to ask him to give to the House a report on the past year's activity of Blue Shield.

BLUE SHIELD REPORT TO IMS HOUSE OF DELEGATES

S. P. Leinbach, M.D., Chairman
Blue Shield Board of Directors

On behalf of the Board of Directors of Blue Shield, may I express appreciation for this opportunity to visit with you about our status at Blue Shield. We know our status has a significant impact on your various offices. This traditional accounting to the House of Delegates is extremely worthwhile in that it enables all of us to take stock of our situation at the moment, compare it with our status of one year ago, and chart our strategy for the coming 12 months.

Please allow me to expand momentarily on the statistical references made by Dr. Bishop. I believe these several figures will provide an effective frame of reference as we devote the next few minutes to an examination of the strengths and weaknesses of Blue Shield at this point in time.

At the close of 1972, the number of Iowans having subscriber status with Blue Shield totaled 1,092,537. When this significant level of participation is translated into dollars and when it is combined with the governmental programs for which Blue Shield has an administrative responsibility, we are able to see just how important this physician-sponsored organization is to the State of Iowa. Please note these four areas of activity:

1) Regular Blue Shield business in 1972 involved payment of $52.3 million to physicians. This may be compared to $45.8 million in 1971.

2) Blue Shield disbursed $20.4 million in 1972 under the Medicare Part B. In 1971, $19.3 million was paid to providers of service under this program.

3) Blue Shield distributed $6.8 million to medical and osteopathic physicians in 1972 under the Medicaid program. This is just slightly more than the $6.4 million figure in 1971.

4) Blue Shield disbursed $682,879 for 1972 services under the CHAMPUS program for military personnel. This is down from the $837,281 paid in 1971.

May I add briefly that the last three programs mentioned are administered by Blue Shield according to strict governmental regulations. We recognize the irritations which they present at times, but we feel we are doing the medical profession a service by acting as the intermediary.

By adding these figures, you will observe that close to $80 million moved through our administrative machinery to the Iowa medical community in 1972 as reimbursement for services provided either to Blue Shield subscribers or participants in the several governmental programs. We are talking here about approximately $36,000 per member of the Iowa Medical Society. From a look at these figures, I think you will agree that we have an active enterprise in which we all—patients and physicians—must take a vital interest.

Please be assured the Iowa Medical Society has continued its strong and helpful involvement in the affairs of Blue Shield during 1972. This involvement has come historically in three principal ways: (1) through the expressions of this House of Delegates, (2) through the week-to-week contact with Society officers and staff, and (3) through the excellent physician representation of the Blue Shield Board of Directors. I believe we have an excellent Blue Shield Board of Directors which is making increasingly good use of the medical expertise of its 19 physician members. It additionally taps the diversified and outstanding talents of its eight lay members. We owe a debt of gratitude to all of these willing, conscientious and public-spirited individuals. And, too, we are indebted to Mr. Bill Recknor and the capable administrative staff working under his direction.

The ongoing wish of the House of Delegates has been for Blue Shield to be responsive to the health care needs and demands of the citizens of Iowa. On various occasions in the past decade this House has called for the abandonment of the series type contract which at one time dominated our portfolio. In response to this request from the House, I am able to report that less than 20 per cent of the Blue Shield contracts now in force are of this older series type; there are approximately 62,000 fewer persons under these coverages than at this time one year ago.

The desire of the public to have broad health care financing programs has been noted by this House of Delegates repeatedly. We have followed an evolutionary process in attempting to meet these public demands. We offered Blue Chip and found it wanting. The Comprehensive contract was introduced and its deficiencies have been noted and its demise is in the offing. We now have placed our major emphasis on the Usual, Customary and Reasonable (UCR) contract. This action has been taken with the knowledge and support of the House of Delegates. While it has its complexities, we are nonetheless enthused by its overall acceptance.

The growth of UCR in a relatively short period of four years has been quite remarkable, and its potential for the future is regarded as very bright. A recent action by the State Insurance Department will give UCR a new impetus in the coming months. I'll explain this in a minute. As of February, participants in the UCR program numbered just over 300,000 and represented nearly 30 per cent of the total Blue Shield subscriber population.

We feel that maximum physician understanding of the UCR concept is essential. This obviously requires repetitive explanations. The UCR program affords equal benefits to the physicians regardless of their relationship to Blue Shield. On occasion, and this has been in less than 5 per cent of the claims, there has been a difference between what the individual physician has submitted as his usual and customary fee and what the Blue Shield UCR program has determined as the appropriate payment for that particular service. In a continuation of our education process, I would recall for you again the definitions which we follow under the UCR concept:

USUAL—The Usual charge is the most consistent charge made by an individual physician to patients for a given service.

CUSTOMARY—The word Customary is applied to a fee when it is within the range of usual charges for a given service billed by most physicians with similar training and experience within a given geographical area.

REASONABLE—The term Reasonable is assigned to a charge when it meets the usual and customary criteria. Reasonable also describes the monetary figure if after medical review it is considered to have aspects which set it apart from the norm for the particular procedure.

In its administration of UCR, Blue Shield uses data which is updated regularly and applies these definitions in formula form to submitted claims and makes payment up to the 90th percentile. As noted a moment

ago, we are paying approximately 95 per cent of physicians' claims for covered services in full as submitted.

We again would urge individual physicians to devise and maintain their own schedules of fees. Individual fees should be submitted in all cases as the usual charge. In a relatively few instances, the Blue Shield UCR payment allowance has been and will be under the submitted charge. Parameters change as periodic updatings occur and this will likely establish the physician within the new customary parameters as they advance.

I am pleased to advise that increasing use is being made by Blue Shield of the peer review services of the Iowa Foundation for Medical Care. Thus, on any question which arises over the handling of a claim, either on the part of Blue Shield or the concerned physician, the professional review capabilities of the Foundation will be called upon. Various decision makers in the health field, including the State Insurance Commissioner, have noted that the Foundation represents the real point of credibility for the medical profession.

At this juncture we might well direct our attention to those factors in the UCR program which have been bugaboos. I refer to the complex "prior agreement" and "hold harmless" aspects of UCR which have been discussed at length the past year or two by the officers and legal counsel of both Blue Shield and the Iowa Medical Society. While no one denies their relevance in certain situations, their magnitude has frankly been exaggerated in terms of widespread difficulty.

In response to a resolution adopted by the 1972 House of Delegates, calling for the Blue Shield Board of Directors to petition the Insurance Commissioner to eliminate from the UCR contract any reference to "hold harmless," I can report to you that contact has been made with the Commissioner; and, for reasons he considers valid, he has denied the request to remove this provision from the contract language.

As many of us do, the Insurance Commissioner believes the resolution of problems which arise in this area belong with the mechanism of peer review and through it he hopes a fair and equitable answer will be found in problem situations.

I would repeat once again for the record that the problems in this area have been minuscule in relation to the total program. The overall potential of the UCR concept to the public and to the profession far exceeds the sparse irritations caused by "hold harmless" and "prior agreement." And, I predict these irritations will diminish even further with the passage of time.

As for the potential of UCR, I am happy to report another action of the Insurance Commissioner which has very favorable implications. On November 30, 1972, we filed a letter with the Commissioner which stated in part: "Iowa Medical Service requests your approval to initiate marketing of the certificate called the 'Usual, Customary and Reasonable' in all groups of 26 or more subscribers effective January 1, 1973. By this time we will have established a 'quality assurance' program in our UCR business utilizing a combination of facets from both our present Medicare pre-and-post payment procedures and those provided by the Iowa Foundation for Medical Care guidelines."

This response was received promptly from the Insurance Department: "Based on statistical evidence presented since your last request for an extension of approval which was dated May 2, 1972, in addition to information gathered during my investigation of your claims processing system and the quality assurance program now in operation, such approval is hereby granted. . . ."

This development permits Blue Shield to market UCR contracts in place of Comprehensive which has well-known inequities for the non-participating physician and his patient. Assurance has also been given that UCR coverage can be extended to non-group subscribers at an appropriate time in the foreseeable future. This action constitutes a favorable response to a 1972 resolution of this House which urges the phasing out of the Comprehensive contract.

In this same exchange of correspondence, and responding again to a resolution adopted by the 1972 House of Delegates, Blue Shield requested the Insurance Department to rule on the matter of benefits being assigned to any physician designated by a subscriber or policyholder. In its response the Insurance Department declared: ". . . it is both possible and required by contract that claim payments involving participating physicians be paid directly to the physician. There is no legal basis, however, for payments made directly to non-participating physician." While the consideration of this subject should be continued and evaluated further, this recent ruling by the Insurance Department is consistent with the Blue Shield philosophy as I interpret it.

I am able to report that another resolution adopted by the 1972 House of Delegates dealing with overlapping membership on the Blue Shield and Foundation Boards has been implemented and there is no dual participating on these bodies.

Speaking finally of another resolution passed by the 1972 House, both Blue Shield and the Medical Society have attempted to be more effective in bringing to the attention of all Iowa physicians information which will help them understand the breadth of the Blue Shield program. In addition to the usual presentation of the Blue Shield report in the July issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY, this comprehensive accounting was reproduced and sent as a separate document to all IMS members. Additionally, as Dr. Bishop mentioned, the field staff is working constantly to help Iowa physicians comprehend the structure and operation of Blue Shield. We believe this joint effort is producing good results.

In an enterprise so vital and so complex we must continually renew our efforts to achieve optimal public understanding and acceptance. Our public service and advertising messages this past year have stressed the need for attention to specific health matters. We believe this is a sound approach worthy of further implementation.

Be assured that the officers and principal administrators are aware of the action taken by the Executive Council of the Iowa Medical Society this month asking that we give maximum attention to proposals at the national level to modify the membership standards for the National Association of Blue Shield Plans. It is our intention to support the retention of the standard fought for several years ago which requires medical society sponsorship of a Blue Shield Plan. This may be a formidable task if we read the signs accurately.

I might mention in passing that Blue Shield has followed matters relating to health maintenance organizations and continues to have an open mind regarding any role we should play in their development in Iowa.

In concluding this report, let me mention the organizational revamping which has occurred at Blue Shield and Blue Cross over the past two months. I believe I

can do this best by quoting parts of the memo distributed to Iowa physicians early in February:

"For many years Blue Cross and Blue Shield have been pleased to share with Iowa physicians and hospitals a major responsibility for the health and well-being of our state's population. As we continue to pursue this important objective together, the elements of cooperation, understanding and responsiveness to current conditions deserve our special consideration. . . .

"In recent weeks we at Blue Cross and Blue Shield have devised a new Statement of Purpose. In it we specifically identify those four elements of society to which we are fundamentally responsible: (1) the individual citizens of Iowa; (2) the providers of health care and their employees; (3) the employees of our Plans, and (4) the corporate community which looks to us for leadership not only in the health field but in the broader citizenship sense.

"Pursuant to the re-statement of purpose and consistent with our previous reference to contemporary responsiveness, we at Blue Cross and Blue Shield have just completed an extensive appraisal of our operational procedures. From this critical examination has emerged a new structural blueprint which contains the administrative potential we believe will allow us to meet the obligations, competitive forces, and national challenges which confront us now and which will increase in the days ahead.

"The consequences of this operational modernization are fourfold and will be of interest to you: (1) The Boards of Directors of Blue Cross and Blue Shield have retained their independence and their policy determination responsibilities; (2) Cooperation between the two Boards has been increased through the establishment of joint board committees. These committees have equal voting representation from each board and are designated to function in these areas: (a) joint management, (b) finance, (c) provider relations, (d) subscriber relations, and (e) external relations. (I might insert here that Mr. Eldon Huston has been designated as the Vice President for Provider Relations in addition to his duties as Assistant Executive Vice President of the Iowa Medical Society), (3) The President of Blue Cross and the Executive Director of Blue Shield will share responsibility for the Chief Executive Office and will report to their respective Boards of Directors, and (4) The operational departments of Blue Cross and Blue Shield will be streamlined into seven principal units to pursue established objectives in a more efficient manner.

"We are confident both subscribers and providers will benefit from this consolidation of Blue Cross and Blue Shield internal functions. This new administrative structure will encourage staff motivation and lift morale as we seek the joint and coordinated objectives of both corporations. We believe the result will be a modern and sensitive operation program.

"Part and parcel of this look to the future is the announced intention of Blue Cross and Blue Shield to consolidate its five bases of operation. The new Ruan Center to be built in downtown Des Moines will be the home of Blue Cross and Blue Shield when it is completed in 1975. The decision to move was made after long study.

"We at Blue Cross and Blue Shield desire your encouragement and support as we implement these measures we have outlined. We want to maximize our service to you the providers of health care as you in turn serve the citizens of Iowa. We will endeavor to keep you posted on these plans as we implement them. We will be pleased to receive your comments and questions."

This seems like a good note on which to conclude. Representatives of Blue Shield will be present at the Reference Committee hearing to elaborate on any items contained in this report. Thank you.

(Resumption of the report by Dr. Wicks.)

During the past year, the officers of the Iowa Medical Society have observed the great progress and growth of the Iowa Foundation for Medical Care, which was created by action of the House of Delegates over a year ago. It is now my pleasure to introduce Dr. John Sunderbruch, President of the Foundation, who will tell you about the work of the organization, and discuss recent developments which may have an overall effect on its structure and function.

IOWA FOUNDATION FOR MEDICAL CARE

J. H. Sunderbruch, M.D., President

Thank you Dr. Wicks. It is a pleasure to give the House of Delegates a progress report on the Iowa Foundation for Medical Care. In its second year the Foundation has moved from the conceptual stage into a viable, functioning peer review organization.

Much has happened to the Foundation this year, more than I can report in this brief summary to the House. Next week a bulletin will be sent to the general membership which will include the information presented here and other pertinent matters. It is our intention to issue similar publications on a regular basis in the future.

At the 1972 House of Delegates Meeting reference was made to a recommendation of the IMS Board of Trustees that the Foundation assume the Society's peer review responsibilities as soon as possible. In July, 1972, these review responsibilities were transferred to the Foundation. Subsequently, the Foundation Board approved a stepped-up medical review program with efficiency and effectiveness as the prime goals. Six review committees have been structured by the Foundation in an effort to balance the workload among all districts. These six district committees each have fifteen members. To facilitate the review process, one-on-one review has been instituted utilizing members of the district committees. In this process a peer review decision is made by a representative member of a district committee. The opportunity to appeal decisions to the full committee remains available. The officers of the Foundation held briefings last fall with each district committee in an effort to provide necessary guidance and support. This year-long educational program has been undertaken to optimize the review capabilities of the committees and to provide the profession with a sound and worthy evaluation mechanism.

I can report that our organizational efforts have been productive. The peer review committees are performing their duties expeditiously and efficiently. The Foundation has received over 200 inquiries asking for clarification on various fees as well as the medical necessity of services. Of these, approximately 150 have been resolved in an average turnaround time of less than 40 days. This constitutes a job well done by the 90 physicians who serve voluntarily on the Foundation's peer review committees.

The past year has seen the Foundation broaden its base of support among Iowa physicians. Foundation members now include approximately 1,200 M.D.s and 150 D.O.s. This represents 55% of the eligible physi-

cians. We hope to encourage many more physicians to join the Foundation and support its objectives of quality medical care for the people of Iowa, with fair and equitable cost reimbursement to the providers.

The Foundation has sought and obtained operating funds from several sources. Shortly after the 1972 House of Delegates meeting the Foundation received two grants totaling approximately $100,000. These grants involved only the obligation that the Foundation employ the funds to organize a quality review mechanism. These finances, plus the $10 initial membership dues, have enabled the Foundation to hire staff, purchase supplies and complete its organizational groundwork.

The Foundation will receive its further funding from those third party carriers interested in using Foundation peer review and willing to abide by its rulings. Assessments to these carriers are and will be based on the amount of market penetration each has in the state. To date the Foundation has consummated working agreements with Blue Cross-Blue Shield and 20 of the largest private insurers in the state.

Of concern to all Iowa physicians is the recently passed amendment to the Social Security law which requires the creation of Professional Standard Review Organizations (PSROs). These organizations are to have the task of monitoring the quality and cost of services performed under Medicare and Medicaid. Initially, the PSRO will be concerned totally with institutional care. Review of out patient care is scheduled to follow at a later date. The new law requires the Secretary of HEW to contract with a qualified review organization by January 1, 1974.

The Foundation Board of Directors has studied the development of the PSRO law cautiously and carefully. Since the Foundation was formed by Iowa physicians to conduct quality review, it appears to be the most qualified and most logical organization to assume PSRO responsibilities. The six peer review committees are now regionally organized to support quality review at the local level. In addition the Foundation has available the IMS Subcommittee on Medical Review's Standards of Health Care to devise preliminary criteria for the review of institutional services. Both of these capabilities appear to be requirements of the new law. The IMS Executive Council has directed the Iowa Foundation for Medical Care to seek responsibility for PSRO functions in Iowa. However, the Foundation now has dues and membership stipulations which preclude it from serving as a PSRO. Two alternatives are being considered by the Foundation. First, it could develop an appendage or corporate affiliate to handle PSRO responsibilities exclusively. Or, secondly it could revamp the existing By-Laws to eliminate the dues requirement and open membership to all licensed practicing physicians. The Foundation Board has concluded that the Foundation was created by the Medical Society to serve the medical profession in the performance of all peer review activities, and these responsibilities should not leave the jurisdiction of the Foundation. Therefore, the Foundation expects to take the necessary action to change its by-laws to conform with the PSRO requirements. It is my hope the Iowa Medical Society will support the Foundation in this action and encourage Iowa physicians to assist us in carrying out PSRO responsibilities.

The Foundation has recently been asked to begin performing PSRO functions in the private sector. Blue Cross-Blue Shield and the Foundation, in an agreement approved by the State Insurance Commissioner, will work together on a program to prepare hospital medical staffs for what is anticipated in the implementation of PSRO. This will include assisting hospitals in organizing their utilization review activities and helping them to apply locally developed standards of care. Our objective in this joint effort is to have hospitals prepared by January 1, 1974, with utilization review systems which satisfy the requirements of the law and which can operate with little external intervention.

To accomplish these many activities the Foundation has increased its staff so it now consists of a Director, Fred Ferree, an Executive Assistant, Rick McMaster, a Nurse Coordinator, Marilyn Heller and two secretaries, Jeanne Waldron and Laurie Callahan. In addition the Foundation has growing pains and is seeking other than IMS facilities. We are actively considering several leads.

We have interviewed and investigated several organizations with computer processing capabilities in an effort to develop our own data bank. The officers and staff of the Foundation are being very thorough in this process.

The Foundation Board has established additional committees to concentrate on several areas of concern. Among these are: A PSRO committee with Dr. John Brinkman, Mason City, as chairman. A Peer Review committee with Dr. Robert Dawson, Estherville, as chairman, and a committee to handle our external relations with other providers of care and consumer representatives with Dr. Joe Monahan, Clinton, as chairman. Our finance, membership and By-Law committees continue to function in their regular capacities.

In summary, the Foundation is cognizant and jealous of the responsibility to maintain professionalism while it performs the peer review functions necessary to guarantee quality medical care at equitable costs to citizens of Iowa. At this point in time we look upon PSRO with all of its unknowns and unwritten regulations with an opportunity to safeguard the freedoms the profession enjoys collectively by accepting voluntary restraints individually. We must bear in mind that Medicare and Medicaid became functional before all regulations were written so I am sure you will agree that a state of readiness is going to be very important. If we are ready, I feel the lawmakers will give us the opportunity we desire.

We are pleased to present this status report on the Iowa Foundation for Medical Care for the information of the 1973 House of Delegates. As mentioned earlier, rules and regulations pertaining to PSRO are still in the preparatory stages at the federal level. You may be assured the officers and administrative staff of the Foundation are doing that spade work which is possible and are awaiting the promulgation of definitive information. In the absence of specific PSRO details, the Foundation believes no action by the House of Delegates is necessary at this time. The Foundation has sought the Society's Executive Council guidance on PSRO and will continue to keep the Council apprised of developments in this important area.

(Resumption of the report by Dr. Wicks.)

Before I conclude this section of the Board of Trustees report, I would like to make just a few comments about Don Taylor, Executive Vice President of the Society, and his remarkable staff.

Don continues his involvement locally, as well as his important work at the national level, which benefits the Society as a whole. He is completing his sixth year as a member of the Advisory Committee to the AMA Executive Vice President which meets quarterly. He

was recently appointed to serve on an advisory committee on PSRO's formed by the American Association of Medical Foundations, as well as on an AMA task force on evaluation of PSRO programs. He serves on a number of national boards of directors. Although the Iowa Foundation for Medical Care is, so to speak, a separate entity, Don continues to be principally responsible for its administration. I think Don and those who work under his direction deserve our commendation.

Unlike the old soldier who just fades away, the problems of the medical profession do not. The great technological advances which have been made, the advent of consumerism, and the cause and effect relationship between social problems and health problems, are having a major impact on the medical profession, and the way in which medical care is practiced and made available to our patients.

However, I can assure you, the physicians who are elected to office in the IMS, and those who volunteer their services to work on committees—as well as members of the administrative staff—work hard in behalf of all members of the profession to preserve the essential ingredient that has led to the great accomplishments in science and in patient care . . . freedom of the physician to seek solutions and to practice medicine in the way that best suits his character and goals.

Respectfully submitted,
R. L. WICKS, M.D., *Chairman*
K. E. LISTER, M.D.
R. H. FLOCKS, M.D.
ERLING LARSON, JR., M.D.
V. L. SCHLASER, M.D.
T. A. BURCHAM, M.D.
J. F. PAULSON, M.D.
J. F. BISHOP, M.D.

At the conclusion of the Board report, Dr. Wicks presented a check for $17,991.24 to John W. Eckstein, M.D., Dean, U. of I. College of Medicine. The check was presented on behalf of the American Medical Association Educational Research Foundation. Dr. Eckstein acknowledged the gift and referred briefly to the excellent working relationship between the U. of I. College of Medicine and IMS.

INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

Presented by R. L. Wicks, M.D., President
Scanlon Medical Foundation/Iowa Medical Society

A special significance is attached to this 1973 report of the Scanlon Medical Foundation/Iowa Medical Society. It is with considerable satisfaction that we draw to the attention of the 1973 House of Delegates this twentieth anniversary of the founding of the Scanlon Medical Foundation.

That the Foundation has existed and grown significantly over twenty years is a tribute to the man whose name it bears and to the physicians who have supported the program. The Foundation was formed in 1953 as the Iowa State Medical Society Educational Fund. In 1963 its name was changed to Iowa Medical Foundation and in 1968 the present designation was authorized.

In two decades nearly 300 Iowans have received financial help from the Foundation as they have studied to become physicians. We are pleased to report further that in this twentieth year of the Foundation loan program a record number of medical students are being served. As you will note from the listing of current student participants in the loan program, which is part of this report, 41 students received assistance during the 1972-73 year. This is an increase of 15 students from last year. As a further indication of the recent growth of the program, you will note that nearly 15 per cent of all loans made during the 20-year life of the Foundation are now with active medical students.

Between April 1, 1972 and April 1, 1973, $56,055 was loaned to Iowans attending medical school. This record outlay of loan funds includes $41,000 in new money deposited in the student loan account this academic year. The bulk of these new loan resources derive from the statewide rubella program of several years ago. Thus, we need to recognize and acknowledge that this recent growth of the student loan program is the result of health concern on the part of many Iowans beyond the medical profession.

The following additional statistical highlights are worthy of your review:

- The principal and interest received between 4/1/72 and 4/1/73 from physicians paying outstanding Foundation loans was $20,527.31.
- The money loaned by the Foundation since the program began totals $478,206.52.
- The loaned amount which has been repaid totals $235,333.36; the amount outstanding is $242,873.16.
- Foundation loans total 290 with 156 of them having been repaid.
- Total resources on loan to the Foundation from physicians, county medical societies and specialty organizations is just over $50,000.

Before commenting further on the status of the loan program, particularly its future status, let me first list the additional activities in which the Foundation has been involved this year: (1) Sponsorship of the Hawkeye Science Fair; (2) Support of the Health Planning Council of Iowa; (3) Completion of payment of a grant to the Des Moines Center of Science and Industry; (4) Participation in the Iowa State Fair Hall of Health; (5) Sponsorship of the Baldridge-Beye Lecture at the recent scientific sessions as well as the Henry Albert Monthly Scientific Presentation in the JOURNAL OF THE IOWA MEDICAL SOCIETY; (6) Support of the Iowa Chapter of the Student American Medical Association through a grant shared in by The Prouty Company of Des Moines; and (7) Partial sponsorship of two conferences in the area of sports medicine.

Included in your packet is an informational folder which has been prepared this year to give interested persons a brief idea of the Foundation program. This is part of our effort to increase the visibility of the Foundation. This folder lists the current members of the Foundation Board of Directors; I call this listing to your attention and do so with an expression of gratitude to these men for the service they render.

The Board of Directors met in Iowa City last November with a group of the recipients in what has grown into a traditional and mutually rewarding experience. The exchange on these occasions has been of benefit to all involved. We are pleased to learn then that funds were available to cover all serious student needs for the 1972-73 academic year.

Looking ahead however to the 1973-74 academic year we face a picture which is not quite as bright. Federal curtailments appear likely to hold supportive funds for medical students at or below this year's level. In addition, and this is our greatest source of concern, the Scanlon Foundation does not presently have the resources to continue its loan program at or even near

the present level. The Foundation will re-loan those sums which are being re-paid by recipients now in practice. But any expansion of the loan program to correspond with the past two or three years is in question. Why? Because we have only about $35,000 available (beyond the amounts being re-paid) to meet the requests of qualified students. When you consider that 25 of the current recipients are sophomores and juniors you quickly realize the difficulty we may face in even renewing these loans, should the request be made.

The Foundation Board has discussed this problem at length. Two options are obvious: (1) Curtail the loan program drastically, or (2) Find the necssary additional resources. The Board will consider the matter further at its Annual Meeting tomorrow and I would request the privilege of appearing before this House briefly on Monday to relay any further recommendations. We believe this is a very important matter which deserves our best judgment in terms of our future strategy. We would be pleased to have your comments and suggestions prior to the Board meeting.

To conclude this report I would like to present for brief remarks the man on the scene with respect to the Foundation loan program. Dr. Lewis H. Jacques is our man on the campus so to speak. He visits with all of the loan applicants personally and decides for the Foundation the student's worthiness to receive a loan. We have asked Dr. Jacques to give you briefly his impressions of the caliber of the loan recipients. Dr. Jacques.

Dr. Jacques spoke briefly and introduced five students who are Scanlon Foundation Loan recipients—Jeffry Life, Thomas Munyon, Nelson Chesney, David Thomas and Bill Marcus. Mr. Thomas expressed appreciation on behalf of the Foundation Loan recipients and told of his concern for future funding of student loans at the U. of I. College of Medicine. He urged continued support of the Foundation by Iowa physicians.

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY
INCOME AND EXPENSE STATEMENT—
DECEMBER 31, 1972

INCOME:		
Contributions and Memorials	$ 4,105.44	
Henry Albert Trust	8,990.31	
Interest on Loans	1,951.86	
Interest on CNB Golden Passbook Savings	4,065.24	
Special Gifts:		
The Prouty Company	250.00	
J. J. Stegman Estate	250.00	
Total Income		$ 19,612.85
EXPENSES:		
Public Service Projects—		
Hawkeye Science Fair	$ 4,200.00	
Health Planning Council of Iowa	2,500.00	
Des Moines Center of Science and Industry	1,535.41	
Governor's Committee on Employment of Handicapped	131.25	
Iowa Health Council State Fair Hall of Health	532.08	
Medical Education Projects—		
Monthly Scientific Articles in IMS Journal	2,000.00	
Iowa Chapter, Student AMA & WA-SAMA	770.00	
Baldridge-Beye Lecture (IMS Annual Meeting)	809.96	
Sports Medicine, Cosponsorship of Conf. on Medical Aspects of Sports 3/30 & Conf. on New Directions in Sports Medicine 12/8-9	400.00	
Student Tuition, Summer Workshops on Alcohol or Other Addictions	225.00	
Administrative—		
Iowa State Bank & Trust Company.	300.00	
Interest Paid on Loans from Physicians	1,867.19	
Salary Allotment	1,500.00	
Legal Services	385.00	
Audit and Tax Return	100.00	
Board Meetings and Travel Expense	466.06	
Miscellaneous Administrative Expense	167.02	
Total Expenses		$ 17,888.97
Net Gain for 1972		$ 1,723.88

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY
BALANCE SHEET—DECEMBER 31, 1972

ASSETS:		
Iowa State Bank & Trust Company	$ 629.39	
Central National Bank & Trust Company	1,961.14	
CNB Golden Passbook Savings	67,776.44	
Notes Receivable from Medical Students	226,966.16	
Student Nurse Loan Fund	3,701.63	
American Scientific Corporation (100 shares)	60.00	
Total Assets		$301,094.76
LIABILITIES AND NET WORTH:		
Notes Payable to Physicians & County Medical Societies	$ 50,075.55	
Note Payable to IMS	5,000.00	
Net Worth:		
Balance 1-1-72 $244,295.33		
Add 1972 Gain 1,723.88	246,019.21	
Total Liabilities and Net Worth		$301,094.76

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY
1972-73 STUDENT LOAN PARTICIPANTS

STUDENT	HOMETOWN	SOPH.	JR.	SR.
Barkman, Harold Jr.	Harlan		X	
Barnes, Brian C.	Clinton			X
Boehme, Larry R.	Waverly			X
Bures, Frank A.	Des Moines		X	
Caldwell, Dennis R.	Cedar Rapids		X	
Cassady, Donald M.	Cedar Rapids		X	
Chandler, Melvin E.	Onawa			X
Chesney, Nelson H.	Newell		X	
Clinton, Joseph E.	Coralville			X
Cobb, Victoria Rae	Fort Dodge		X	
Collison, Robert	Oskaloosa			X
Evans, William B.	Davenport	X		
Foster, Earl J.	Brooklyn		X	
Froehlich, Richard T.	Everly			X
Fulton, Michael N.	Columbus Junction			X
Gruhn, Stanley W.*	Denison			X
Haygood, Jerry W.	Bettendorf		X	
Hennessee, John L.	Davenport			X
Kinkead, Lewis R.	Cedar Rapids		X	
Krogh, Steve S.	Iowa Falls		X	
Kuentzel, William P.	Winterset			X
Life, Jeffrey S.	Iowa City	X		
McGuire, Michael H.	Cushing	X		
Marcus, William L.	Iowa City	X		
Moser, Paul H.	Burlington			X
Munyon, Thomas G.	Des Moines	X		
Nassif, Edward G.	Cedar Rapids	X		
Ough, James L.	Davenport		X	
Peacock, Thomas A.	Des Moines			X
Plank, Carl J.	Iowa City			X
Reibold, Robert J.	Carroll			X
Robinson, Merl	Cedar Rapids		X	
Rube, Gerald S.	Sioux City		X	
Sellers, Larry W.	Russell		X	
Spoden, James E.	Guttenberg		X	
Stulc, Jaroslav P.	Cedar Rapids			X
Thomas, David L.	Camanche		X	
Thomsen, Timothy A.	Mt. Vernon		X	
Wegerman, Alan K.	Cedar Rapids		X	
Whalen, John E.	Elkader			X
Williams, James J.	Ottumwa		X	

* Gruhn was on the program April and May 1972—received his degree June '72.

JUDICIAL COUNCIL

E. E. Gamet, M.D.
Chairman, Judicial Council

For several years the Judicial Council has shared with other IMS officers concern with respect to a trend for physicians to elect not to belong to the Iowa Medical Society and the American Medical Association.

The Councilors have a major responsibility in encouraging physicians to become active members of organized medicine at all levels. An effort of the Judicial

Council has resulted in a more structured campaign in 1973 to promote IMS membership. A large amount of organizational planning has been devoted to implementing a membership program which will educate physicians on the reasons a unified medical profession is essential. This is of particular significance since organized medicine is subject to more attacks from outside its ranks, as well as from within, than any other time in its history.

Early in March, 1973, a letter from the IMS President was directed to all physicians who had previously been members of the Iowa Medical Society, but for one reason or another were currently not active members. To date the results of these contacts have not been overwhelming, although 14 physicians have rejoined the Iowa Medical Society. Later in March a letter from the IMS President was sent to physicians who were members of the IMS in 1972 but whose 1973 dues had not been received. This letter reminded these nonmembers of their delinquent status and a large number have since paid 1973 dues. The work of the Councilors has been coordinated with the officers of the county medical societies and their help solicited. Each Councilor has been given a complete listing of those physicians within his district who are still not IMS members. The Councilors will be establishing additional membership contacts in cooperation with county medical society officers and other interested physicians. The records list a number of physicians who practice in Iowa but who have not joined the Iowa Medical Society. Since the avenue for membership in the IMS and the AMA is through the county medical society, we ask that county officers encourage all physicians who become members of their county society to also join the Iowa Medical Society and the American Medical Association. As the Society learns of physicians moving to Iowa, a letter of welcome is sent from the IMS President. This needs to be reinforced by personal or phone contact at the local level by county medical society officers.

In reviewing the membership records we note with pleasure that 115 new members have joined since October, 1972, and in addition 14 former members have been reinstated for a total of 129. Even so, we still have a net loss in membership of 26, due to 51 physicians moving out of the state, 26 deaths and 78 former members who have not yet renewed their 1973 membership.

The reports before this House of Delegates should serve to demonstrate dramatically the need for a strong state medical society. As delegates, we encourage you to be ambassadors and express to your colleagues the importance in membership in organized medicine at all levels. Only through unity can there be strength.

The Judicial Council will continue to encourage physicians to become active in the Iowa Medical Society. Plans are already being made to refine the membership program in 1974 and into the future. These efforts must be successful and we solicit your help.

Respectfully submitted,
E. E. GAMET, M.D., *Chairman*
C. L. KELLY, M.D.
H. G. MARINOS, M.D.
J. M. RHODES, M.D.
P. J. MONNIG, M.D.
R. E. HINES, M.D.
A. M. DOLAN, M.D.
J. E. TYRRELL, M.D.
J. F. COLLINS, M.D.
K. E. GARBER, M.D.
HORMOZ RASSEKH, M.D.
E. E. LINDER, M.D.

Supplemental Reports of Standing Committees

NECROLOGY COMMITTEE

(The Speaker asked the members of the House of Delegates to stand while E. E. Gamet, M.D., Chairman of the Judicial Council, read the names of IMS members who died in 1972. The list appears on page 308 of this issue of the JOURNAL.)

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

I. Judicial Council Minimum Attendance Requirements

The 1972 House of Delegates adopted the following resolution and referred it to the Standing Committee on Articles of Incorporation and By-Laws.

"*Resolved,* That the matter of minimum attendance by IMS councilors be referred to the Standing Committee on Articles and By-Laws with instructions (1) to prepare appropriate language to implement this recommendation, and (2) in doing so to consider provisions whereby the represented and involved county medical societies would be notified if and when their councilor has attended less than 60 per cent of the meetings of the Judicial Council on an unexcused basis. And further, that when at the end of any one year a councilor has not attended 60 per cent of the meetings his councilor seat will be declared vacant."

The Committee in consultation with legal counsel found that this resolution could best be implemented through amendment to the Articles of Incorporation.

The Standing Committee on Articles of Incorporation and By-Laws therefore recommends adoption of the following resolution by the 1973 House of Delegates.

"*Resolved,* That Article IV, Section 15 be amended by adding the following at the end of the first paragraph of said Section 15:

'Also, a vacancy in his office shall automatically be created if any Councilor, who has been a Councilor for the period beginning with the last day of an annual meeting and ending on the day preceding the last day of the next succeeding annual meeting, shall fail, without excuse acceptable to the Judicial Council, to attend 60 per cent of the meetings of the Judicial Council held during such period. The Judicial Council shall promptly notify the component society or societies comprising that Councilor's district of the vacancy in his office.' "

II. Alternate Delegates to the American Medical Association

During the final session of the 1972 House of Dele-

gates, when the House was considering amendments to the Articles of Incorporation and By-Laws, an additional amendment was proposed from the floor, as follows: "In each odd number year it shall elect three alternate delegates to the House of Delegates of the American Medical Association." The motion was duly seconded and adopted.

Following adjournment of the House, legal counsel was asked to review the amendment as adopted. Legal counsel opined that because its subject-matter was not presented to nor considered by the Reference Committee the motion was "out of order," but since it went unchallenged the amendment as adopted by the House of Delegates was valid.

Implementation of the amendment requires other revisions in the Articles of Incorporation. The Standing Committee on Articles of Incorporation and By-Laws has reviewed, in consultation with legal counsel, the further amendments that are necessary if there is to be more than one alternate delegate to the AMA House of Delegates. These are as follows:

1. Amend Article IV, Section 8 by striking the second and last paragraph thereof and by inserting in lieu thereof the following:

"In the event any of the regular delegates to the House of Delegates of the American Medical Association is unable or unwilling to attend a meeting of such House of Delegates, and in the further event there is not a sufficient number of alternate delegates able and willing to serve in place of such regular delegate or delegates at such meeting, the President shall appoint a member or members of the Executive Council to serve as alternate delegate or delegates at such particular meeting."

2. Amend Article IV, Section 16 by striking therefrom the following sentence:

"The alternate delegate to the American Medical Association shall be a non-voting member of the Executive Council."

and by inserting in lieu thereof the following sentence:

"Alternate delegates to the American Medical Association shall be non-voting members of the Executive Council."

In the interest of providing the delegates background information as to why the By-Laws were originally changed to reduce the number of alternate delegates from three to one, the Standing Committee on Articles of Incorporation and By-Laws has researched past actions of the House of Delegates and considers it an obligation to present these details to the House of Delegates before the House is called upon to act on the amendments the committee has presented. The committee believes this to be important since the amendment offered from the floor in 1972 did not receive consideration by the House of Delegates convened as a committee of the whole or the Reference Committee on Articles of Incorporation and By-Laws.

In 1958 the Eighth Councilor District submitted to the House a resolution as follows:

Subject: Expenses for Alternate Delegates to the AMA

WHEREAS, The alternate delegates to the American Medical Association are asked to attend and be active at the AMA medical meetings, and

WHEREAS, It is important that the alternates be in training to perform as delegates; therefore be it

Resolved, That the alternate delegates to the American Medical Association have their expenses paid to the AMA medical meetings.

The resolution was referred to a reference committee and the House adopted its recommendation as follows:

"After carefully considering this recommendation, the Board of Trustees respectfully requests permission of the House of Delegates to study the entire subject of Iowa State Medical Society representation at meetings of the American Medical Association in the hope that a plan can be developed for designation of representatives to the American Medical Association that will provide the utmost in efficiency and economy."

The Board of Trustees, in reporting to the 1959 House of Delegates, submitted the following recommendations:

(1) That there be one regularly elected alternate delegate of the ISMS.

(2) That in order that this officer be fully informed of the policies and official actions of the ISMS that he be made a member of the Executive Council with all privileges and duties thereof.

(3) That the alternate delegate attend all conventions of the House of Delegates of the AMA with expenses paid, to which regular delegates are sent.

(4) That in the event of the absence of a regular delegate from a convention of the House of Delegates of the AMA, that the alternate delegate assume all the responsibility and duties of the office of delegate at this convention.

(5) That in event two or more regular delegates be unable to attend a convention of the House of Delegates of the AMA that the president of the ISMS be authorized to appoint from the Executive Council the necessary additional number of members to attend as delegates of the Society, thus assuring informed representation.

(6) That in event of the absence of the alternate delegate from a convention of the House of Delegates of the AMA that the president of the ISMS be instructed to appoint from the Executive Council a member to act as alternate delegate at this convention.

The Board further submitted for consideration of the House, appropriate amendments to the By-Laws to implement its recommendations. Upon recommendation of the reference committee, the House of Delegates adopted amendments to implement most of these changes. Therefore, since January, 1962, the IMS has elected one alternate delegate who has been authorized to attend all sessions of the AMA House of Delegates. This arrangement has been accepted by the American Medical Association and has in fact resulted in the Iowa Medical Society having four delegates to the AMA of equal knowledge and expertise, although only three have an actual vote within the House of Delegates. The first alternate delegate elected was E. M. Smith, M.D., who at the time was from Wright County. Dr. Smith was elected as an AMA delegate beginning January 1, 1966, and C. E. Radcliffe, M.D., of Iowa City, was elected an alternate delegate. These two physicians have served in succession in these capacities since that date.

After a complete review of this matter, the Standing Committee on Articles of Incorporation and By-Laws recommends that the House of Delegates adopt the following amendment which would return the By-Laws to its former status; i.e., one alternate delegate to the American Medical Association:

Resolved, That Chapter III, Section 6 of the By-Laws of the Iowa Medical Society, as amended, be and

hereby is further amended by striking the second paragraph which reads: "In each odd-numbered year, it shall elect three alternate delegates to the House of Delegates of the American Medical Association." and by inserting in lieu thereof the following:

"In each odd-numbered year, it shall elect one alternate delegate to the House of Delegates of the American Medical Association."

It is necessary that amendments to the Articles and By-Laws be first "submitted to a committee for study and report" before action is taken by the House of Delegates and it has been customary to refer amendments recommended by this committee to a reference committee in order that the House of Delegates could take appropriate action in the light of the report of the reference committee. It will be difficult to follow this customary procedure because the By-Laws provide (Chapter IV, Section 5) that the first order of business at the last session of the House of Delegates shall be the election of officers. Accordingly, the election of an alternate delegate or three alternate delegates, as the case may be, would normally occur before this House could act on the reference committee report. It is possible to "suspend the rules" by a two-thirds vote and permit action to be taken on the reference committee report on Monday morning prior to the election, but this could result in confusion and delay.

An alternative procedure is for the House of Delegates to serve as its own "reference committee" by resolving itself into a "Committee of the Whole" to give due consideration to this important matter. This procedure permits the House to resolve the matter at this first session so that it will be known whether there will be one or three alternate delegates to be elected at the final session on Monday. Should the House adopt the recommendation of this committee that the By-Laws be amended to provide for only one alternate delegate to the AMA, then it would not be necessary to adopt the two amendments to the Articles set forth previously in this report and the election of the one alternate delegate can proceed in accordance with the report of the Nominating Committee at the final session of this House on Monday.

On the other hand, if this House, after thoroughly reviewing this report as a Committee of the Whole, rejects the recommendation of this Committee on Articles and By-Laws and amends the Articles to be consistent with the present by-law provision that there be three alternate delegates to the AMA House of Delegates, then the matter will be resolved today. This will permit nominations from the floor following the report of the Nominating Committee today.

Recommendation: Mr. Speaker, the Standing Committee on Articles and By-Laws recommends adoption of the following resolution:

Resolved, That Chapter III, Section 6 of the By-Laws of the Iowa Medical Society, as amended, be and hereby is further amended by striking the second paragraph which reads: "In each odd-numbered year, it shall elect three alternate delegates to the House of Delegates of the American Medical Association." and by inserting in lieu thereof the following:

"In each odd-numbered year, it shall elect one alternate delegate to the House of Delegates of the American Medical Association."

and further recommends adoption of the following resolution:

Resolved, That this House of Delegates resolve itself into a Committee of the Whole to consider this report and to report back to the House of Delegates and that this House take appropriate action with respect to amending the Articles and By-Laws at this session of the House.

Mr. Speaker, by direction of the Committee, I move the adoption of both of the foregoing resolutions.

Respectfully submitted,
J. F. BISHOP, M.D., *Chairman*
L. R. FULLER, M.D.
D. A. HOWELL, M.D.
K. J. JUDIESCH, M.D.
E. G. KETTELKAMP, M.D.

The House of Delegates sustained the motion to become a Committee of the Whole. Dr. Skinner was named chairman. The matter of the number of alternate delegates to the AMA was discussed at length. Basis for the discussion was the Section II portion of the Report of the Standing Committee on Articles of Incorporation and By-Laws. Based on recommendations submitted by the Committee of the Whole, the House of Delegates, when reconvened, approved the recommended changes in the Articles to increase the number of AMA alternate delegates from one to three. The several amendments needed to implement this action were approved by the House of Delegates.

At the request of J. H. Kelley, M.D., chairman, IMS Committee on Legislation, the House of Delegates agreed to receive a supplemental report from the Committee in executive session. This report was referred to the Reference Committee on Legislation and Miscellaneous Business. Following a status report on the Iowa Medical Political Action Committee, given by Erling Larson, Jr., M.D., IMPAC chairman, the House of Delegates was convened in open session.

NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 25, 1973 and agreed upon the following slate to be presented to the House of Delegates today.

President-Elect	Ralph L. Wicks, M.D., Boone
Vice President	Robert M. Chapman, M.D., Cedar Rapids Maurice E. Kraushaar, M.D., Fort Dodge Henry R. Light, M.D., Grinnell
Speaker of the House of Delegates	Lynn D. Caraway, M.D., Amana Homer L. Skinner, M.D., Carroll
Vice Speaker of the House of Delegates	John R. Scheibe, M.D., Bloomfield Robert D. Whinery, M.D., Iowa City
Trustee (3 year term)	A. J. Havlik, M.D., Tama Ralph E. Hines, M.D., Des Moines
Delegate to AMA (2 year term)	Christian E. Radcliffe, M.D., Iowa City
Alternate Delegate to AMA (2 year term)	John M. Rhodes, Sr., M.D., Pocahontas
Councilor, 1st District (3 year term)	Clarkson L. Kelly, Jr., M.D., Charles City
Councilor, 4th District (3 year term)	Daniel M. Youngblade, M.D., Sioux City
Councilor, 5th District (To complete an unexpired term, term to expire at Annual Meeting, 1975)	Clarence H. Denser, Jr., M.D., Des Moines
Councilor, 6th District (3 year term)	A. M. Dolan, M.D., Waterloo
Councilor 11th District (3 year term)	Hormoz Rassekh, M.D., Council Bluffs
Blue Shield Liaison Delegates to IMS (Two to be elected)	S. P. Leinbach, M.D., Belmond J. R. Scheibe, M.D., Bloomfield C. W. Seibert, M.D., Waterloo J. D. Ver Steeg, M.D., Des Moines

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee.

It will be noted that there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, under the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and submitted as a part of its report to the House of Delegates.

Respectfully submitted,
L. J. O'BRIEN, M.D., *Chairman*
V. H. CARSTENSEN, M.D.
H. W. ALCORN, M.D.
R. J. DAWSON, M.D.
J. L. GARRED, M.D.
R. K. BUNTEN, M.D.
L. O. GOODMAN, M.D.
K. J. JUDIESCH, M.D.
J. F. FOSS, M.D.
K. A. GARBER, M.D.
J. D. KIMBALL, M.D.
A. L. SCIORTINO, M.D.
W. A. SEIDLER, JR., M.D.

Following the report of the Nominating Committee, Dr. Caraway asked for nominations from the floor. The following physicians were nominated for the office of Alternate Delegate to the AMA—J. R. Anderson, M.D., Boone; Erling Larson, Jr., M.D., Davenport; L. J. O'Brien, M.D., Fort Dodge; and J. W. White, M.D., Dubuque. Dr. L. D. Caraway, Amana, was also nominated but asked that his name be withdrawn. The Speaker announced that with the permission of the House the three vacancies in the office of Alternate Delegate would be filled on the basis of the three physicians who receive the highest number of votes. This recommendation was not challenged.

SUBCOMMITTEE ON MEDICAL REVIEW

(Referred to the Reference Committee on Insurance and Medical Service.)

The Subcommittee, since publication of its Handbook report, has attempted to hold two meetings, but inclement weather prevented the Committee from holding a formal session.

As Chairman of the Committee, I have one item to present for the information and consideration of the House of Delegates. The Subcommittee on Medical Review has, as needed, consulted with Blue Shield on questions relating both to its private programs and the governmental programs it administers, i.e. Medicare, Medicaid and CHAMPUS. A subject the Subcommittee and the Iowa Foundation for Medical Care have both reviewed is the manner in which Blue Shield determines a "customary charge" under both governmental and private programs. For the benefit of the House of Delegates we wish to submit a chronological review of how "geographical regions" for the determination of "customary charges" have been developed.

Shortly after implementation of the Medicare program, Blue Shield, as Medicare Carrier, was mandated by federal regulation to determine a "customary charge" or "prevailing charge" giving consideration to the specialty of the physician and the geographical region in which he practices. During 1966 and 1967 the IMS Committee on Cost of Medical Care consulted with Blue Shield to assist in the determination of appropriate Medicare payment guidelines, i.e., specialty and geographical area. The subject of most significance in this report pertains to geographical areas. The committee determined that the then existing seven congressional districts would be followed as geographic districts and the physicians at the University of Iowa College of Medicine would be considered a separate area.

The House of Delegates in 1967 received an informational report on this subject but was not asked to give formal approval since this was a matter of jurisdiction of the Department of HEW and the Medicare carrier.

In 1970 the Boone County Medical Society presented a resolution to the House of Delegates suggesting a geographical rearrangement of the "customary fee areas." The resolution was referred to the Subcommittee on Economics of Health Care for its consideration and report. An intensive study was undertaken as to the effect of dividing the state into more or fewer geographical regions. Since the Committee was unable to arrive at any acceptable alternative it recommended that the present areas be retained until more experience was available.

As the Subcommittee in the past few years has discharged its task as a state claims review committee, there has been a general feeling that the most acceptable and fair mechanism would be to establish the entire State of Iowa as a geographical area for determination of customary charges. The present geographical areas do not conform to any other existing geographical breakdown of the state and there is confusion between this geographical breakdown and (1) the 12 councilor districts, (2) the six Iowa congressional districts, and (3) the six districts for Foundation peer review, none of which corresponds to the other. The Subcommittee in 1971 recommended to the Executive Council that . . . "The IMS consider the feasibility of establishing one statewide profile, both for medical care guidelines and fee norms, for use by peer review and the Iowa Foundation for Medical Care." The Executive Council approved the recommendation.

In March 1973 the Iowa Foundation for Medical Care reiterated its position that Blue Shield should be encouraged to establish the State of Iowa as one area for determining "customary charges" for both its public and private programs.

It is assumed in all these deliberations that any determination of "customary charges" will continue to be done with consideration given to the specialty of the physician, i.e., internist compared to internist, orthopedic surgeon to orthopedic surgeon, etc., etc. The physicians at The University of Iowa College of Medicine are still considered a separate geographical region, although this question is under review by the peer review mechanism of the Iowa Foundation.

For the benefit of the House we should redefine what is the current definition of "customary charges" . . . "the word CUSTOMARY is applied to a fee when it is within a range of usual charges for a given service billed by most physicians with similar training and experience within a given geographic area."

The consideration of this total subject becomes even more significant as Blue Shield converts more and more contracts from low level income contracts to the Usual, Customary and Reasonable contract of Blue Shield. This conversion is progressing quite rapidly and is in keeping with recommendations of this House of Delegates. We therefore find ourselves in a position where the same geographical areas as originally established in 1967 still exist for determination of "customary charges." This applies both to Blue Shield governmental and private programs. It is felt by both the Subcommittee and the Iowa Foundation that a statewide determination of "customary charges" would be the most acceptable approach because it would eliminate complaints as to possible favoritism between specific geographic regions.

The best statistical information available indicates that such a change would not have an aggregate negative effect, although it is possible a small number of individual physicians may be adversely affected. No specific recommendation other than the 1971 recommendation is being submitted since it has not been possible for the Subcommittee to meet and reaffirm its earlier action. It is understood that the House will meet again in October, so perhaps the House will elect to delay an action on this matter until the fall meeting which could provide opportunity for additional study.

Respectfully submitted,

R. S. GERARD, M.D., *Chairman*
D. D. ALDRICH, M.D.
D. C. ALFTINE, M.D.
A. R. ANNEBERG, M.D.
G. H. ASHLINE, M.D.
T. P. BOARD, M.D.
A. W. BOONE, M.D.
R. R. CARLSON, M.D.
W. A. CASTLES, M.D.
D. E. CONKLIN, M.D.
M. H. DUBANSKY, M.D.
H. S. FRENKEL, M.D.
V. R. HELMANN, M.D.
H. H. HILDEBRAND, M.D.
P. K. HUGHES, M.D.
L. E. ROSEBROOK, M.D.
R. D. ROWLEY, M.D.
R. C. SMITH, M.D.
J. C. TIMMERMAN, M.D.
H. F. TRAFTON, M.D.
J. D. VER STEEG, M.D.

MEDICO-LEGAL COMMITTEE

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

The report of the Medico-Legal Committee which appears in the 1973 Handbook for the House of Delegates refers to a survey of county society officers and members of the House of Delegates. This survey was conducted by the Committee to ascertain the interest and likely participation of Iowa physicians in a Society sponsored professional liability insurance program.

The three-question survey of approximately 300 Iowa physicians had a 56 percent response level. Following are the percentage responses to the questions:

1. Do physicians in your area currently regard malpractice coverage as . . .

Readily Available	84%
Hard to Obtain	13%
Other	3%

2. Is main concern expressed by your colleagues over . . . (some surveys contained more than one response)

Premium Cost	93%
High Number of Claims	13%
Difficulty in Obtaining Coverage	7%
Poor Relations with Insurance Company	7%

3. Would physicians in your area likely switch their coverage to an IMS-endorsed program with features at least equal to present individual coverage . . .

Yes	56%
No	12%
Unknown	31%

Various comments and observations were added to several of the responses. These generally related to the third question and emphasized the need for comprehensive coverage, use of a reputable company, lower premium costs and stability of coverage.

While this response from physician leaders in Iowa suggests a majority are interested and willing to participate in a Society-sponsored program, the 56 per cent affirmative response can hardly be interpreted as a strong plea for a group coverage.

After approximately two years' study of this subject and recognizing the national trend toward medical society sponsored or endorsed programs, the Medico-Legal Committee is still hesitant to advocate the group approach in Iowa. The Committee intends to continue its analysis of professional liability and will consider new information which becomes available. Along this line, a unique insurance program instituted by the Florida Medical Association has been brought to the Society's attention in recent weeks. The FMA has established a stock company to provide various forms of insurance, including professional liability, for the Florida physicians. Further information will be sought on this approach to see if it has any application in Iowa.

Should the 1973 House of Delegates wish to instruct the Committee to pursue a course different from the one outlined in this supplemental report, the Committee will attempt to be responsive.

On a related matter, the 1972 House of Delegates referred to the Medico-Legal Committee a resolution urging Society support of state legislation to make a losing party responsible for all court and legal fees involved in a civil liability action, and also cause said party to pay a reasonable fee to the winning attorney. Various additional ramifications are embodied in the resolution.

The Medico-Legal Committee concurs the cost of defense in cases brought on a contingency basis by a plaintiff's attorney produces a financial injustice when the finding favors the defense. However, it is felt that modification of existing procedures by state statute would be most difficult to achieve and would not be in order at this particular time. Further study of the matter is warranted however.

Respectfully submitted,

C. H. DENSER, JR., M.D., *Chairman*
G. H. ASHLINE, M.D.
K. K. HAZLET, M.D.
J. H. KELLEY, M.D.
W. M. KRIGSTEN, M.D.
R. P. LAGONI, M.D.
R. D. ROWLEY, M.D.
J. M. TIERNEY, M.D.
W. V. WULFEKUHLER, M.D.

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

In 1970 the Iowa Medical Society House of Delegates approved the following language having to do with the termination of pregnancy:

"Resolved, That the Iowa Medical Society be on record in favor of new legislation that would leave the matter of the termination of a pregnancy between the woman and her physician.

"Resolved, That such legislation be in accordance with the following guidelines: (1) The termination of a pregnancy shall only be performed by a physician and surgeon licensed to practice in the State of Iowa; (2) The procedure shall only be done in a hospital; (3) No physician, hospital or hospital personnel shall be required to participate in the termination of a pregnancy; (4) Provisions shall be made so that no legal action can be taken against any hospital or person refusing to administer services relating to these procedures.

"Resolved, That the Iowa Medical Society should lend its knowledge and assistance, when called upon, in support of legislation on this subject, using the above-named guidelines."

In view of the January decision of the U. S. Supreme Court to lift restrictions on a woman's right to a physician-performed abortion during the first three months of pregnancy, the following statement of elaboration is recommended by the Subcommittee on Maternal and Child Health for approval by the 1973 House of Delegates. It should be acknowledged that much of the content of this statement has been drawn from material approved by the American College of Obstetricians and Gynecologists and has been compiled in collaboration with officials at The University of Iowa College of Medicine. Following is the policy statement proposed by the Subcommittee:

Pregnancy termination is a surgical procedure. For its performance adequate facilities, equipment and personnel are required to assure the highest standards of patient care. Pregnancy termination should be performed only by physicians who are qualified to identify and manage the complications that arise from the procedure.

First trimester abortions (up to 12 weeks gestational age) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State Department of Health.

Pregnancy termination beyond the first trimester should be performed in a hospital. It is hoped that the majority of terminations of pregnancy would be done under 12 weeks and only a limited number between the 12th and 20th weeks.

From the end of the 20th week until the onset of fetal viability (normally between the 24th and 28th week) pregnancy termination would best be done only for medical or genetic indications. Beyond the period of viability termination should be subject to the approval of a Hospital Termination of Pregnancy Committee and only when the action based upon appropriate judgment is necessary for the preservation of the life or health of the pregnant woman.

Facilities for the performance of first trimester terminations should include appropriate surgical, anesthetic and resuscitation equipment. In addition the following should be provided:

1. Verification of the diagnosis and duration of pregnancy.
2. Preoperative instructions and counselling.
3. Recorded preoperative history and physical examination, particularly directed to identification of pre-existing or concurrent illness or drug sensitivity that may have a bearing on the operative procedures or the anesthesia.
4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.
5. Prevention of Rh sensitization.
6. A receiving facility where the patient may be prepared and receive preoperative medication and observation prior to the procedure.
7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.
8. Postoperative instructions and arrangements for followup, including family planning advice.
9. Reporting of legally induced abortions is essential. The State Department of Health should assume the responsibility for collection of the necessary data and preservation of the confidentiality of such information.

It is recognized that termination of pregnancy may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept termination of pregnancy.

The usual informed consent, including operative permit, should be obtained. A patient who is married or 19 years of age (18 years of age effective July 1, 1973) may give her own consent. For other patients consent must be given by parent or legal guardian.

It is important that the provision of abortion services not interfere with the care of other obstetric-gynecologic patients or with residency training programs in obstetrics and gynecology. Consideration should be given by hospitals to providing facilities where termination of pregnancy can be performed with minimal disruption of other hospital functions.

The Subcommittee is aware of the guidelines on this subject which have been approved by the medical staffs of several hospitals in Iowa. In addition, it is the understanding of the Subcommittee that University Hospitals in Iowa City has developed guidelines embodying many of the principles contained in this report and will make them available to the public either simultaneously with any action of the House of Delegates or soon after.

Respectfully submitted,
G. L. BAKER, M.D., *Chairman*
W. J. BALZER, M.D.
CHARLOTTE FISK, M.D.
J. L. KEHOE, M.D.
D. O. NEWLAND, M.D.
ELIZABETH D. PROCTER, M.D.
C. W. SEIBERT, M.D.
C. W. STEVENS, M.D.
J. M. WALL, M.D.
J. J. WEYER, M.D.

Supplemental Report of Special Committee

SUBCOMMITTEE ON COMPONENT BILLING

(Referred to Reference Committee on Insurance and Medical Service.)

The 1972 House of Delegates acting on Resolution #14 from the Scott County Medical Society and Resolution #16 from the Polk County Medical Society charged an appropriate committee with responsibility to further explore the question of "component billing" relating to payment for surgery and surgical assistants.

The President, in consultation with the Board of Trustees, appointed this special committee and referred to it the following action of the House:

"Resolved, That the present committee or a special committee be appointed composed of representatives from surgical specialties and primary physicians to further explore this question and report to the appropriate policy-making body.

"Resolved, That the Committee give consideration to the establishment of the following components as comprising the total fee-for-service charges for complete care: (1) patient work-up; (2) preoperative care, surgery and post-operative care; and (3) surgical assistant."

The Committee, in writing this report, is assuming that the majority of House members are fully familiar with this question since it has been before the House several times in the past few years. For the information of those House members who are new, attached to this report are the findings and recommendations of a special committee created in 1969 which resulted in adoption by the House of Delegates of a five component billing system for a surgical illness.

The Committee on Component Billing has reviewed in detail past actions of the Iowa Medical Society on this subject and is thoroughly familiar with the varying viewpoints that have been expressed. The Committee has met with officials of Blue Shield (Medicare carrier) to review the manner in which physicians have utilized the component billing system. The committee is informed that Blue Shield began coding claims using the component system in May of 1972. This has provided Blue Shield with approximately nine months of data based on the component system with which it is now processing and making payment on physicians' claims.

In June of 1972, following an educational program for physicians and their offices on the component billing system, Blue Shield conducted an informal telephone survey and found that most physicians' offices, wherein the component billing system was particularly applicable, were utilizing the system. In April, 1973, Biue Shield conducted an informal review of approximately 100 claims picked at random and found that physicians' offices were billing in accordance with the component system.

The Committee has considered various alternatives, such as (1) continuation of the five component billing system, (2) recommend adoption of a three component billing system, and (3) a recommendation to return to a policy which left this to the local level and not recommend any specific component billing system. It appears to the Committee that the present component system has permitted a more accurate reflection of the fees charged by Iowa physicians for specific surgical services. Recognizing the varying practices followed in separate areas of the state, this system seems to be accommodating the vast number of Iowa doctors. There has been no apparent pressure exerted for physicians to change their mode of practice to accommodate the component billing system, which was a fear expressed by some physicians. Quite possibly the future may bring additional efforts to further define components of a surgical illness but the Committee sees no immediate trend in this regard.

The bulk of objections expressed to the Committee appear to reveal a lack of understanding of how the component system is to function. Education efforts will be continued.

The Committee recommends that the five component billing system continue to be followed where and when applicable. It is further recommended that the special Committee on Component Billing be discharged and any further considerations on this subject be referred to an appropriate existing committee of the Iowa Medical Society.

Respectfully submitted,
L. L. ZAGER, M.D., *Chairman*
J. H. DUNLEVY, M.D.
C. A. JACOBS, M.D.
T. R. NICKNISH, M.D.
R. B. STICKLER, M.D.
J. M. HENNESSEY, M.D.

REPORT ON PAYMENT FOR SURGERY AND SURGICAL ASSISTANTS UNDER MEDICARE

The 1969 House of Delegates in considering the State Claims Review Committee report endorsed the appointment of a special Subcommittee to meet with the Medicare Carrier and representatives of HEW to evaluate the administrative problems involved in payment of surgical and surgical assistants' fees. The House was aware of the problems inherent in the payment of surgical and surgical assistants' fees and recognized that customs vary in different parts of the state which variation further complicates the handling of these claims.

Since the beginning of Medicare the Iowa Medical Society and the Medicare Carrier have each received many inquiries from physicians both in family practice and surgical specialties as to exactly how payment for surgery and surgical assistants is determined under Medicare. The Carrier has always been guided by the official policy of the Iowa Medical Society.

During its deliberations the Subcommittee conducted a most exhaustive study of the historical background of Medical Society policy on this subject. This included action of this House, the Executive Council, the Judicial Council and the AMA House of Delegates and Judicial Council.

Basic to the Committee thinking has been agreement that treatment for a surgical illness includes the following five components:

(1) The patient workup.
(2) Normal pre-operative care.
(3) Surgery.
(4) Surgical Assistant.
(5) Normal post-operative care.

The difficult administrative problem of the Carrier is to determine which of these services were rendered by a physician who has submitted a claim for payment. Historically, in many parts of Iowa claims for surgery have been submitted on a "package charge" basis, which has included the charge for all five components, even though more than one physician may have been

involved in the care of the patient. Because of this factor the surgical charge information used by the Carrier has been maintained on this "package charge" basis. Charge profiles have not been developed on each of the five separate components since most claims received list one charge representing all five components. Even when a physician has not rendered all five services, many physicians have been reluctant to list a charge less than their normal charge for all five components because of the effect this might have on their computer profile. All of these factors have too many times resulted in an incorrect or inadequate payment being rendered to one of the physicians involved in the treatment of a surgical illness.

Based on its study the Committee offers the following observations:

1. The Medicare Claim Form (SSA-1490) includes the following certification statement:

"(A physician's signature certifies that physician services were personally rendered by him or under his personal direction.)"

Rendering of a statement "for professional services" to a patient even though not assigned and not on a Medicare Claim Form (SSA-1490) is interpreted by HEW as carrying the same degree of certification by the physician as signing the Medicare Claim Form.

The Federal False Claims Act provides for civil recovery of double damages for claims (this includes Medicare claims) filed falsely. In addition, criminal fraud provisions apply when intent to defraud is established.

To conform to the above HEW takes the position that Medicare billings must clearly identify the exact scope of services for which billing is being made. *If the claim includes a billing for the services of any other physician, specific identification of that physician and the charge for his service must be included on the claim form.*

2. Charges submitted for surgery usually include all five components and the Carrier's charge information is maintained on this basis. Where a surgeon performs an operation but does not render all five components the Carrier should be able to determine a reasonable charge for only those components of care actually rendered. If another physician has rendered one or more of the components, the Carrier should be in a position to determine the reasonable charge for only those components. *However, the total reasonable charge for the services of both physicians cannot exceed the reasonable charge for the five components had one physician billed for the full range of services.*

3. The determination of a reasonable charge under Medicare needs refined. One of the basic principles of Medicare is for each physician to determine his own charge for a medical and surgical service. For the Carrier to accurately determine a reasonable charge, claims submitted must describe and define the exact services rendered in order to permit grouping of only identical services for purposes of determining a reasonable charge.

4. The Carrier should establish customary charge profiles for the components of a surgical service in order for it to build appropriate prevailing charges for the payment of claims. To accomplish this goal, claims must clearly identify the exact services personally rendered by the physician submitting the claim.

Two points seem to evolve from the Committee's study:

1. Medicare is based on the physician placing a value on his service and the program paying for that service within the charge guidelines established through federal law and regulations. In order to fulfill this commitment the Carrier must be able to identify exactly what surgical service components the physician rendered:

(1) Was it all five components?

(2) Was it assistant surgery only?

(3) Was it assisting plus workup and pre- and postoperative care?

(4) Was it only the surgical operation?

Each possible combination must be treated as a discrete service and valued as such in the Carrier's record if the physician and patient are both to be treated with equity.

2. The total financial obligation of the program cannot be increased solely because of any revision or change that might occur in the Medicare billing and/or payment process.

The Committee recommends that in the future all claims submitted by physicians should indicate which of the five components of a surgical illness are represented by the charge listed on the claim form. Such itemization will result in a more equitable administration of third party programs, particularly Blue Shield, Medicare and Medicaid.

To implement this recommendation the Committee feels that an educational program should be undertaken by the Iowa Medical Society and Blue Shield. Such an educational program should involve all physicians but perhaps with special emphasis on physicians practicing family medicine or a surgical specialty.

The Committee believes that nothing in this recommendation will require a change in the long established policy of the Iowa Medical Society with regard to payment for surgery and surgical assistants. *However, if the recommended program is to succeed, great attention will need to be devoted to the completion of claims by physicians.*

The Committee recognizes that close liaison will be required between the Iowa Medical Society and the Carrier to assure physicians that the Carrier has methods to properly identify the code claims for surgery. Only with this assurance could the program be favorably received.

At this point, Dr. Schlaser read a letter from American Association of Medical Assistants, State of Iowa, expressing regret that it could not sponsor a coffee bar. They extended best wishes to all members of the House of Delegates for a most successful meeting.

RESOLUTIONS

PAGE COUNTY MEDICAL SOCIETY

NO. 1. ADOPTION OF CURRENT PROCEDURAL TERMINOLOGY

(Referred to the Reference Committee on Insurance and Medical Service.)

WHEREAS, The present four-digit system for Procedural Terminology used by Blue Shield is obsolete and does not cover all services performed by the family practitioners and other specialty groups; and

WHEREAS, The American Medical Association and other state medical societies and specialty groups have adopted the five-digit system as recommended in the Current Procedural Terminology; and

WHEREAS, Most of the private insurance companies have adopted this coding; therefore be it

Resolved, That the Iowa Medical Society adopt and recommend that all members use the five-digit system as described in the Current Procedural Terminology.

MARION COUNTY MEDICAL SOCIETY
NO 2. REVISED MEMBERSHIP TENURE FOR ELECTION TO OFFICE IN IMS

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The Articles of Incorporation and By-Laws of the Iowa Medical Society now prohibit a capable, young, willing and deserving member from holding an office in the Iowa Medical Society due to a time limitation of five years membership; therefore be it

Resolved, That Article IV, Section 2, lines 24 and 25 of the Articles of Incorporation of the Iowa Medical Society which now read "membership in good standing in this Society for the five years immediately preceding election." be changed to read "membership in good standing in this Society immediately prior to election"; and be it further

Resolved, That Chapter I, Section 2, lines 9 and 10 of the By-Laws of the Iowa Medical Society which now read "and has been a member of this Society in good standing for five years." be changed to read "and is a member of this Society in good standing."

MARION COUNTY MEDICAL SOCIETY—REVISED PER LETTER OF APRIL 20, 1973
NO. 3. HANDLING OF RESOLUTIONS

(Referred to the Reference Committee on Reports of Officers.)

WHEREAS, In this period of rapid change in mode of medical practice greater involvement of the members is deemed desirable; and

WHEREAS, A large percentage of attendance at meetings is unattainable; and

WHEREAS, It is very difficult for the House of Delegates to ascertain the desires of the membership as a whole; therefore be it

Resolved, That (1) the various resolutions introduced by the county medical societies be printed, as in the Delegates' Handbook, in an issue of the IMS NEWS BULLETIN which precedes the annual meeting of the Iowa Medical Society; (2) A ballot be included whereby the member may vote on each resolution, the results being immediately distributed to the delegates and alternates for the edification, only, of the members of the House of Delegates; and (3) The results of this poll be printed in a succeeding issue of the IMS NEWS BULLETIN.

DALLAS-GUTHRIE COUNTY MEDICAL SOCIETY
NO. 4. RURAL MEDICAL FAMILY PRACTICE UNITS

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, We as practicing physicians in rural Iowa are concerned about adequate and continuous medical care for the people in the rural areas of Iowa; and

WHEREAS, Satellite units are being set up from metropolitan medical centers as "Rural Medical Family Practice Units" on an office hours-office practice type of service in rural areas, and

WHEREAS, These services do not include 24-hour, seven-day-a-week care for the people they are purportedly serving; and

WHEREAS, Medical family practice includes continuous care, both as far as the continuous and whole care of the patient is concerned, and in continuous coverage during the day and night; therefore be it

Resolved, That "Rural Medical Family Practice Units" be required to be manned by physicians 24 hours per day, so that adequate, continuous medical care may be rendered to the people in the rural areas, and near-by physicians will not be asked to see these patients after normal daytime office hours.

CLINTON COUNTY MEDICAL SOCIETY
NO. 5. PUBLIC RELATIONS VIA NEWS MEDIA

(Referred to the Reference Committee on Reports of Officers.)

WHEREAS, The image of the physician of the United States is constantly deteriorating as the result of the constant attack by the socialist element in our society, and with the tacit approval and aid of our present news media; and

WHEREAS, The physician cannot adequately present his side as to relative merits of the various plans proposed; therefore be it

Resolved, That the Iowa Medical Society purchase controlling interest in one or more radio stations and/or newspapers in this state, with this media then to be utilized to present the views of the Iowa physician as well as the other views currently being presented.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 6. IMMUNIZATION OF CHILDREN

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

Resolved, That the Iowa Medical Society encourage and support immunizations for all children, but other than on a compulsory basis.

BLACK HAWK COUNTY MDICAL SOCIETY
NO. 7. LIFE MEMBERSHIP

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

Resolved, That eligibility for Life Membership in the Iowa Medical Society be changed to read, "that the involved member has been in active practice for forty years and been a member in the State Society for forty years."

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 8. MEDICAL CARE IN CORRECTIONAL INSTITUTIONS

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, The function of the Iowa Medical Society is the promotion of good medical care in the State of Iowa; and

WHEREAS, The quality of medical care at the correctional institutions in the State of Iowa has been called into question by the lay press; and

WHEREAS, The inmates at such institutions do not have a choice of physicians; therefore be it

Resolved, That the Iowa Medical Society appoint a committee to investigate the quality of medical care at the correctional institutions in the State of Iowa and make any appropriate recommendations that might be indicated by its findings.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 9. VD & DRUG ABUSE EDUCATION COMBINED WITH REALISTIC EDUCATION IN HUMAN SEXUALITY

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, Resolutions by state and national organizations in education, medicine and public health over

the past ten years have been of limited value in changing the conduct of the citizenry—youth and oldsters—as regards continued experimentation, and

WHEREAS, State laws pertaining to instruction in these areas in elementary and secondary school curriculum are enforced, but need some additional element of "peer" instruction and/or example teaching to involve parents, and

WHEREAS, Students will not accept the admonitions of instructors and/or parents regarding drug use when they observe these individuals taking pep pills, alcohol and tranquilizers, and

WHEREAS, Avenues of peer instruction, via Junior Chamber of Commerce and like organizations, have provided a more effective means of communication to the young on VD and sex education, and

WHEREAS, Evidence is rapidly accumulating on the dangerous interaction of drugs and alcohol in studies of blood levels in Las Vegas drunken driving arrests, to cite one, therefore be it

Resolved, That the Iowa Medical Society re-affirm its stand in the three areas of VD, drug abuse and sex education, and be it further

Resolved, That institutions of higher education be urged to engage in preparation of teachers who are able to cope with these problems, and at the same time, establish health education workshops for both teachers and lay individuals who are interested in becoming involved in such programs.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 10. ACTS OF VIOLENCE PORTRAYED ON TV

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, TV producers have become more and more permissive in their use of daring portrayals to depict rape, incest, homosexuality, drug use and abuse (including alcoholism), VD, prostitution, sadism and other acts of perversion, sexual and otherwise, and

WHEREAS, Police and F.B.I. studies have shown a definite correlation between patterns of actual crime and episodes presented on television and/or movies, and

WHEREAS, Television is practically impossible to monitor and supervise in terms of viewers, therefore be it

Resolved, That the Iowa Medical Society go on record as condemning such permissiveness as deleterious to the moral education of our youth, and therefore be it further

Resolved, That when such exposure is an integral part of the development of the plot and/or course of disintegration or regeneration of character, it has good educational and enlightenment value and should be used as such, and therefore be it further

Resolved, That the NEA and AMA in their national meetings propose means by which such measures of "Preventive Medicine" can be perpetrated on the viewing public as part of remedial therapy.

POLK COUNTY MEDICAL SOCIETY
NO. 11. SURGICAL FEES

(Referred to the Reference Committee on Insurance and Medical Service.)

WHEREAS, The Iowa Medical Society, by previous action of the House of Delegates, supports the fragmentation and division of Surgical fees into five (5) component parts i.e. initial examination, pre-operative preparation, "cutting experience," assistant's fee and post-operative care, and

WHEREAS, Contrariwise, the Iowa Medical Society traditionally maintains a strong position for fee-for-service for all physicians, be it

Resolved, That the Iowa Medical Society support the fee-for-service concept for the surgical fee and allow no division of fees in order to allow payment to any other person and further that when other medical fees and/or assistant's fees are justified, they will be paid by all third parties as separate and distinct payments for separate service.

POLK COUNTY MEDICAL SOCIETY
NO. 12. REAPPORTIONMENT OF DELEGATES TO THE IOWA MEDICAL SOCIETY

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The representation within the House of Delegates of the Iowa Medical Society continues to be on a county basis with unequal representation, and

WHEREAS, Previous attempts to change the By-Laws of the Iowa Medical Society to establish a one-to-one representation on a statewide basis has not been approved, therefore be it

Resolved, That the Iowa Medical Society amend its By-Laws to provide that delegates be selected on a basis of Councilor Districts with one delegate from each district and an additional delegate from each district for each 25 members or major fraction thereof, more than an original 25.

MARION COUNTY MEDICAL SOCIETY
NO. 13. DETERRING NUISANCE SUITS

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, Malpractice litigation is increasing in numbers, a change in our state law, whereby the losing party in civil litigation shall not only pay court costs but also a reasonable fee to the winning party's attorney, we believe, will solve our malpractice problem, and

WHEREAS, This proposed state law would eliminate most nuisance suits, some estimate 80%, for when a plaintiff with a questionable complaint knows beforehand, that he has to pay the successful defendant attorney's fee, if the plaintiff loses his case in court, most plaintiffs who are so quick to sue now under our contingent fee system, will not sue, and

WHEREAS, The poor plaintiff will also be taken care of under this proposed state law, if he has a legitimate complaint, for he will be provided with a lawyer and the means to sue, therefore be it

Resolved, That the Iowa Medical Society prepare and actively support a bill to present to the Iowa Legislature, and seek the active support of other state organizations which stand to benefit, for proposed legislation which would provide: 1) That the losing party in civil litigation shall not only pay all court costs, which he already usually does, but that in addition he shall pay a reasonable fee to the winning party's attorney; 2) That the poor man shall be able to sue if he has a justifiable case (as determined in medical cases by a county committee composed of the county attorney, the president of the county bar association, the president and secretary of the county medical society and the clerk of court). (In non-medical cases the committee shall be represented by the board of super-

visors, the county attorney and the clerk of court.) If either committee in its investigation finds the poor man has a justifiable case, a unit of the State will provide him an attorney and the necessary means so he can comply with the law, in the very few instances where he loses his case in court; 3) That there shall be established in connection with this proposed law a schedule of justifiable fees that the losing party has to pay to the winning party's attorney; 4) That before any plaintiff can begin civil litigation he must present to the clerk of court an affidavit, and additional proof if the clerk of court deems it necessary, showing that he has the means to pay court costs and the defendant's attorney fee, if he, the plaintiff, should lose his case in court; and be it further

Resolved, That the resolution shall be submitted to the American Medical Association at its next meeting for its approval for state legislation.

POLK COUNTY MEDICAL SOCIETY
NO. 14. BLUE SHIELD

(Referred to the Reference Committee on Insurance and Medical Service.)

WHEREAS, The economic climate has changed since adoption of the usual, customary and reasonable concept as a result of a more socialistic medical atmosphere, insurance commissioner's rulings, and price freeze for physicians,

WHEREAS, It is also a venerable custom of long standing to acknowledge Blue Shield by resolution in the House of Delegates, be it

Resolved, That updating of our insurance program is inevitable if we are to be responsive to society. To achieve this, changing from the present usual, customary and reasonable concept to a fee schedule with inflationary flexibility is suggested for consideration.

POCAHONTAS COUNTY MEDICAL SOCIETY
NO. 15. CONFIDENTIALITY OF PHYSICIANS' HOSPITAL RECORDS

(Referred to the Reference Committee on Insurance and Medical Service.)

WHEREAS, Third Parties have become increasingly audacious in their insistance on pursuing physicians' confidential hospital records; and

WHEREAS, This practice is contrary to the time-honored pledge of confidentiality to patients; and

WHEREAS, Further in-roads in this area will lead to guarded and incomplete hospital medical records; therefore be it

Resolved, That the Iowa Medical Society support the proposal that Third Parties not be given access to physicians' hospital records without expressed permission of the physician and his patient.

POCAHONTAS COUNTY MEDICAL SOCIETY
NO. 16. NEW GUIDELINES FOR HEW FAMILY PLANNING PROJECTS

(Referred to the Reference Committee on Insurance and Medical Service.)

WHEREAS, HEW, through its Family Planning Projects, has seen fit to issue new guidelines which include: (a) Covered services "free" without respect to income; (b) fixed fee schedule; (c) compulsory referral of Papanicolaou smears to a California laboratory; and

WHEREAS, These Family Planning Projects request signed participation agreements and specify unnecessarily cumbersome forms to be used; therefore be it

Resolved, That the Iowa Medical Society protest this invasion of the private practice of medicine and encourage physicians to use the "usual and customary" fee principle and to continue to specify laboratories of their choice.

LIFE AND ASSOCIATE MEMBERSHIPS

LIFE MEMBERSHIP RECOMMENDED ON THE BASIS OF 50 YEARS' PRACTICE AND 30 YEARS' MEMBERSHIP

County	Name
Appanoose	Frank B. Leffert, M.D., Centerville
Black Hawk	Sylvester W. Barnett, M.D., Cedar Falls
	Wade O. Preece, M.D., Waterloo
Cherokee	James H. Wise, M.D., Cherokee
Clarke	Herbert E. Stroy, M.D., Osceola
Dubuque	Frank J. Piekenbrock, M.D., Dubuque
Mitchell	John O. Eiel, M.D., Osage
Polk	Dennis H. Kelly, Sr., M.D., Des Moines
	Clement A. Sones, M.D., Des Moines
Scott	Louis H. Kornder, M.D., Davenport

ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

County	Name
Appanoose	Ralph R. Edwards, M.D., Centerville
Black Hawk	Sterling A. Barrett, M.D., Waterloo
	Marshall D. Huston, M.D., Cedar Falls
	Fred R. Sloan, M.D., Waterloo
Boone	Donald L. Cross, M.D., Boone
Chickasaw	Arlo L. Murphey, M.D., Fredericksburg
Floyd	Ray A. Fox, M.D., Charles City
Howard	Paul A. Nierling, M.D., Cresco
Jasper	Edward A. McMurray, M.D., Kellogg
Jefferson	John W. Castell, M.D., Fairfield
Polk	Donald H. Kast, M.D., Des Moines
	Benjamin F. Kilgore, M.D., Des Moines
	Allan B. Phillips, M.D., Des Moines
Woodbury	Lewis J. Dimsdale, M.D., Ft. Lauderdale, Fla.

The physicians nominated for each of these membership categories were approved unanimously.

The special presentation of a portrait of Donovan F. Ward, M.D., Dubuque, Past President, American Medical Association, was made to the House of Delegates. The portrait was presented on behalf of Dr. Ward's family by his daughter, Janice Walton, and unveiled by his daughter, Sally Wilke. It was received by Dr. Kenneth Lister, president of IMS, on behalf of the Society, with expression of gratitude and assurance it would be displayed appropriately at IMS Headquarters Building.

Dr. Lister announced that Dr. William E. Owen, St. Ansgar, had been awarded a Special Certificate of Humanitarian Service by the AMA. This recognition was the result of Dr. Owen's participation in the AMA's Voluntary Physician for Vietnam Program. He served in Vietnam on three occasions: 1966, 1969, and more recently, 1972-1973.

The Speaker announced the meeting places for the various reference committees and said they would convene at 8:00 a.m., Sunday. Delegates were informed the House of Delegates would convene Monday, April 30, at 8:30 a.m. in the Grand Ballroom of the Fort Des Moines Hotel. The House adjourned at 6:45 p.m.

MONDAY SESSION, APRIL 30, 1973

The Monday session of the House of Delegates was called to order at 8:30 a.m. The House approved the taking of attendance by registration cards. There were 92 delegates, 11 voting alternates and 16 ex-officio members present. Delegates' packets and ballots were distributed at the time of registration.

COUNTY	DELEGATE
Allamakee	C. R. Rominger *(Alternate)*
Appanoose	A. S. Owca
Black Hawk	G. R. Clark
	C. D. Ellyson
	R. S. Gerard
	D. E. Conklin
	A. M. Dolan *(Alternate)*
Boone	J. R. Anderson *(Alternate)*
Bremer	V. H. Carstensen
Buchanan	L. J. Flage
Calhoun	R. P. Ferguson
Carroll	J. E. McGill
Cerro Gordo	W. V. Wulfekuhler
	H. W. Alcorn
	G. H. West, Jr.
Cherokee	G. E. Michel
Chickasaw	J. C. Carr
Clay	Mary L. Gannon
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Dallas-Guthrie	E. E. Lister
	W. A. Seidler, Jr.
Davis	H. M. Perry
Decatur-Ringgold	E. E. Gamet
	D. E. Mitchell
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	L. F. Wallace
Dickinson	D. F. Rodawig, Jr.
Dubuque	J. A. Pearson
	J. W. White
Emmett	R. J. Dawson
Floyd	E. E. Schmiedel
Franklin	R. E. Munns
Fremont	F. M. Ashler
Grundy	D. R. Kruschwitz
Hamilton	G. A. Paschal
Hancock-Winnebago	N. D. Thede
Hardin	T. C. Graham
Harrison	J. W. Barnes
Humboldt	J. H. Coddington
Iowa	B. M. Byram
Jackson	J. A. Broman *(Alternate)*
Johnson	R. C. Brown
	S. W. Greenwald
	C. E. Hartford
	K. J. Judiesch
	C. E. Radcliffe
	R. D. Whinery
	N. N. Llewellyn *(Alternate)*
	R. E. Rakel *(Alternate)*
	A. C. Wise *(Alternate)*
Jones	A. P. Randolph *(Alternate)*
Lee	G. C. McGinnis
	W. B. Kasiske
Linn	C. R. Aschoff
	R. M. Chapman
	R. W. Conkling
	R. A. Sautter
Mahaska	S. A. Smith
Marion	P. C. Todd
Marshall	W. T. Shultz
	L. O. Goodman
Monona	J. L. Garred
Montgomery	Oscar Alden
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Pocahontas	James Gannon
Polk	John Hess, Jr.
	W. R. Hornaday, Jr.
	J. I. Hostetter
	N. W. Irving, Jr.
	J. E. Kelsey
	R. K. Bunten
	D. C. Young
	A. N. Smith
	D. O. Newland
	J. W. Green, Jr.
	N. K. Rinderknecht
	L. O. Ely *(Alternate)*
	C. H. Denser, Jr. *(Alternate)*
Pottawattamie-Mills	M. E. Olsen
	Hormoz Rassekh
	A. L. Sciortino
	R. K. Fryzek
Poweshiek	H. R Light
Scott	D. A. Bovenmyer
	A. W. Boone
	J. F. Collins
	J. C. Donahue
Shelby	J. H. Spearing
Sioux	E. B. Gossmann, Jr.
Tama	A. J. Havlik
Union-Taylor	R. H. Kuhl
Wapello	L. E. Coppoc
	R. P. Meyers
Wayne	K. A. Garber
Webster	L. J. O'Brien
	D. S. Egbert
Woodbury	P. J. Monnig *(Alternate)*
Wright	C. P. Hawkins

LIAISON DELEGATES

S. P. Leinbach C. W. Seibert

EX-OFFICIO MEMBERS OF THE HOUSE

K. E. Lister
R. H. Flocks
Erling Larson, Jr.
V. L. Schlaser
T. A. Burcham
R. L. Wicks
J. F. Paulson
J. F. Bishop
J. M. Rhodes
L. D. Caraway
L. W. Swanson
H. J. Smith
E. M. Smith
H. L. Skinner
J. H. Sunderbruch
R. F. Birge

Dr. Schlaser read the minutes of the April 28 meeting of the House of Delegates and the House approved them.

Willard Scrivner, M.D., President, Illinois Medical Society; James Gosman, M.D., President, Indiana State Medical Society; George Martin, M.D., President, Minnesota State Medical Society; Raymond Holden, M.D., AMA Trustee; Mr. Neil Sutherland, Assistant Director, Public Affairs Division of AMA; and Mr. Gary Fetgater, Assistant Director, Department of Planning Development of AMA, were introduced by Dr. Caraway and recognized by the House.

The election of officers occurred and the following physicians were chosen:

President-elect	R. L. Wicks, M.D., Boone
Vice-president	R. M. Chapman, M.D., Cedar Rapids
Trustee	A. J. Havlik, M.D., Tama
Speaker of the House	L. D. Caraway, M.D., Amana
Vice Speaker of the House	R. D. Whinery, M.D., Iowa City
Delegate to AMA	C E. Radcliffe, M.D., Iowa City
Alternate Delegates to AMA	J. R. Anderson, M.D., Boone Erling Larson, Jr., M.D., Davenport J. M. Rhodes, M.D., Pocahontas
Councilor, District 1	C. L. Kelly, Jr., M.D., Charles City
Councilor, District 4	D. M. Youngblade, M.D., Sioux City
Councilor, District 5	C. H. Denser, Jr., M.D., Des Moines
Councilor, District 6	A. M. Dolan, M.D., Waterloo
Councilor, District 11	Hormoz Rassekh, M.D., Council Bluffs
Blue Shield Liaison	S. P. Leinbach, M.D., Belmond
Delegates to IMS	C. W. Seibert, M.D., Waterloo

Dr. Caraway commended the members of the Reference Committees, invited delegates to next meeting of House of Delegates to serve on Reference Committees, and asked inquiries be addressed to Speaker, IMS Headquarters Office. He then informed delegates of the proper procedure for debate and voting on Reference Committee Reports.

REFERENCE COMMITTEE REPORTS

The following Reference Committee reports were acted upon by the House of Delegates.

REPORTS OF OFFICERS

At its open hearings beginning at 8:00 a.m. on Sunday, April 29, 1973, the Reference Committee on Reports of Officers received additional information and comments on several of the specific items referred to it. Following are the recommendations on the four reports and two resolutions considered by the Committee:

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES—SECTION II—FINANCES

The fiscal situation of the IMS was reviewed, and pertinent comments were made by the Chairman of the Board of Trustees, the President, and administrative staff. Specific attention was called to the five major expense items of the Society—i.e., salaries, travel for officers and employees, committee functions (including legislative), taxes, and the IMS JOURNAL.

The Reference Committee concurs with the Board of Trustees that it is indeed distasteful to operate the Society at a deficit, such as our experience in 1971, with a deficit of $38,000, and in 1972, with a lesser deficit of $33,000. The Committee also expresses its concern that at the present time an actual building depreciation account has not been established in order to assure that appropriate funds will be available to underwrite necessary expenses and replacement costs in maintaining the Headquarters building.

The Committee acknowledges that the total building and property debt has been paid, and this is most commendable. It is also very well aware—as must be most physicians—that the cost of doing business is continually on the rise; hence, the steps that have been taken by the Board of Trustees to reduce expenses without curtailing important programs of the Society are appreciated.

Decreasing membership is of great concern to the Reference Committee, not only because of the financial consequences, but for reasons of unity and solidarity among members of the medical profession, as well. Even though an effort is being made to recruit more members for the IMS, there has been a net loss of 26 physicians in 1973 due to 51 physicians moving out of the state, 26 deaths, and non-renewal of memberships by 78 physicians. It should be underscored, however, that the IMS operates at a level of activity and effectiveness which compares most favorably with state medical societies with substantially more members and dues income.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That the Reference Committee on Reports of Officers be designated by the House of Delegates to continue to serve in this capacity until the fall meeting. In the interim, this committee will conduct an *impartial* and *in-depth* study of the Society's finances. At the fall meeting, specific recommendations will be presented in an attempt to solidify our financial future. Recommendations will also be made at that time regarding any necessary change in dues. All delegates are urged to discuss the Board of Trustees Supplemental Report re Finances, and the Reference Committee's recommendation, with their colleagues, and submit any pertinent comments or suggestions to the Reference Committee in advance of the fall meeting.

Mr. Speaker, I move the adoption of this Resolution.

The Reference Committee calls attention to the fact that the IMS JOURNAL continues to experience a reduction in its deficit even in light of increasing production costs and a decrease in advertising revenue.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That Marion E. Alberts, M.D., Des Moines, Scientific Editor, and Don Neumann, Managing Editor, be complimented for their efforts in not only publishing an excellent journal, but in keeping the cost down as much as possible.

Mr. Speaker, I move the adoption of this Resolution.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES—SECTION I—GENERAL ACTIVITIES

The Reference Committee was pleased to review the generally positive information contained in the Board's Supplemental Report concerning general activities, and wishes to commend the following:

The Board of Trustees, Dr. Lloyd Gugle of Ottumwa, Chairman of the 1973 IMS Program Committee, and the members of that committee for their efforts in arranging a most successful and outstanding Scientific Session in Nassau;

The Health Planning Council of Iowa, and its officers and staff, for assisting in the formation of local and area-wide health planning councils prior to the dissolving of the organization early this year;

The officials of the Iowa Medical Society and the University of Iowa College of Medicine for their efforts in developing joint scientific and educational programs;

The Iowa Academy of Family Physicians for spearheading a program to obtain state funds to establish family practice residency programs in various communities in the state and also for joining with the Iowa Medical Society and the College of Medicine in seeking appropriate legislative action;

The 300 physicians who voluntarily man the committees of the IMS and carry out the "nuts and bolts" work of the Society;

The progress and work of the Iowa Foundation for Medical Care. In this connection, the Reference Committee encourages all physicians to become members of this organization.

Mr. Donald L. Taylor, Executive Vice President, for his outstanding work and leadership as the chief executive officer of the Society, and other members of the IMS staff for their performances in all aspects of the Society's operation.

PRESIDENT'S ADDRESS

In keeping with the opening remarks of the address of Dr. Kenneth Lister, President of the Iowa Medical Society, the Reference Committee merely wants to state, in terms of his efforts and achievements during the past year, "he ran a sub-four minute mile."

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That this House of Delegates officially extend its appreciation to Dr. Lister for a job well done.

Mr. Speaker, I move the adoption of this Resolution.

JUDICIAL COUNCIL REPORT

The Reference Committee is pleased that a full scale membership recruitment program has been undertak-

en by the Judicial Council, and underscores the importance of the delegates in promoting the involvement of their colleagues in organized medicine at all levels.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That the Judicial Council continue its program of seeking increasing membership and physician involvement in the Iowa Medical Society.

Mr. Speaker, I move the adoption of this Resolution.

RESOLUTION NO.2—INTRODUCED BY THE MARION COUNTY MEDICAL SOCIETY HANDLING OF RESOLUTIONS

The Marion County Medical Society Resolution calls for the dissemination of all resolutions introduced by county societies to be distributed to the membership in advance of the Annual Meeting of the House, with opportunity for the members to "vote" on the resolutions, the results of such vote being made available to the delegates for their information. During discussion, it was suggested that the intent of this resolution could be accomplished by printing the resolutions in the IMS JOURNAL that is published just prior to the annual and regular meetings, or by a special News Bulletin, or by distribution of the Delegates' Handbook to all members of the IMS.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That Resolution No. 3 not be approved, and that the Board of Trustees be given authority to develop an appropriate mechanism of informing the members of the IMS about Resolutions to be considered by the House of Delegates during its annual and regular meetings.

Mr. Speaker, I move the adoption of this Resolution.

RESOLUTION NO. 5—INTRODUCED BY THE CLINTON COUNTY MEDICAL SOCIETY PUBLIC RELATIONS VIA NEWS MEDIA

The Clinton County Medical Society recommends the IMS purchase controlling interest in one or more radio stations and/or newspapers in the state for purposes of presenting the views of Iowa physicians.

Even though this idea is an appealing one, it does not seem feasible in light of existing financial considerations.

Mr. Speaker, I move Resolution No. 5 be disapproved.

Prior to completing the Reference Committee hearing, several comments were made by those in attendance regarding the Scanlon Medical Foundation/Iowa Medical Society, and the informational report on the Foundation which was presented to the House on Saturday.

In reference to medical student loans, it was pointed out that the demands on the medical student loan program of the Scanlon Foundation will become even greater because of the loss of federal funds that previously were available to medical students.

All Iowa physicians are interested in helping our young potential colleagues complete their medical educations, and our financial assistance is required if we are not to lose some of these future physicians due to a lack of adequate funding.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That in an effort to stimulate physician donations to the Scanlon Medical Foundation/Iowa



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Medical Society, reference to the Scanlon Foundation be included on the Iowa Medical Society annual dues billing statement so that physicians can remit a voluntary contribution if they choose to do so, and be it further

Resolved, That county medical societies which have excess funds be encouraged to make them available to the Scanlon Medical Foundation/IMS for medical student loan purposes.

Mr. Speaker, I move the adoption of these Resolutions.

This concludes the report of the Reference Committee on Reports of Officers.

Respectfully submitted,
D. O. NEWLAND, M.D., *Chairman*
J. H. CODDINGTON, M.D.
R. J. DAWSON, M.D.
H. M. PERRY, M.D.
R. A. SAUTTER, M.D.

LEGISLATION AND MISCELLANEOUS BUSINESS

The Reference Committee on Legislation and Miscellaneous Business met at 8 a.m. on Sunday, April 29, 1973 to consider reports and resolutions assigned to the committee. Following completion of the hearings, the committee met in executive session to consider the issues.

RESOLUTION NO. 6—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY IMMUNIZATION OF CHILDREN

"*Resolved,* That the Iowa Medical Society encourage and support immunization for all children, but other than on a compulsory basis."

Your Reference Committee is in complete agreement with the intent of this resolution, but feels that in order to state the intent of the resolution more clearly, one change should be made.

RECOMMENDATION: Your Reference Committee recommends adoption of the following resolution as amended:

Resolved, That the Iowa Medical Society encourage and support immunization for all children on a voluntary basis.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 13—INTRODUCED BY THE MARION COUNTY MEDICAL SOCIETY DETERRING NUISANCE SUITS

The substance of this resolution is that the Iowa Medical Society pursue legislation which would deter the initiation of nuisance suits through regulation of contingent fees and by other measures. It is the feeling of your Reference Committee that the Medico-Legal Committee is doing an excellent job in studying the problem of vexatious litigation. In view of the obvious ramifications of pursuing such legislation and in view of the continued study of this question, your Reference Committee feels at this time it is inappropriate for the IMS House of Delegates to act on this issue.

RECOMMENDATION: *Resolved,* That Resolution No. 13 be not adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

SUPPLEMENTAL REPORT ON THE MEDICO-LEGAL COMMITTEE

Your Reference Committee commends C. H. Denser, M.D. and his committee for their continued efforts in studying the most complicated subject of medico-legal problems.

RECOMMENDATION: Your Reference Committee recommends adoption of the following resolution:

Resolved, That the Report of the Medico-Legal Committee and recommendations to remain alert and be interested in insurance programs as they are developed in the country be accepted, and that further study be made of the Florida and other programs as they may develop and the Committee report back to the House of Delegates at its next session.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 4—INTRODUCED BY THE DALLAS-GUTHRIE COUNTY MEDICAL SOCIETY RURAL MEDICAL FAMILY PRACTICE UNITS

"*Resolved,* That "Rural Medical Family Practice Units" be required to be manned by physicians 24 hours per day, so that adequate, continuous medical care may be rendered to the people in the rural areas, and near-by physicians will not be asked to see these patients after normal daytime office hours."

The Reference Committee is in sympathy with the sentiments expressed by Resolution No. 4 and has thoroughly evaluated the numerous ramifications related to "Satellite Clinics" and Rural Medical Family Practice Units. Your Reference Committee was informed that some such facilities have part-time physician coverage while others may have principally physicians' assistants available. We are concerned, at this time, with the impact that physicians' assistants may have on a community. It is conceivable that the presence of a physicians' assistant may preclude that community from recruiting a physician it may actually need. There is also the possibility that physicians' assistants in "Satellite Clinics" may force physicians in the area to consider moving their practices elsewhere.

RECOMMENDATION: Due to the complexities of this subject, your Reference Committee recommends adoption of the following resolution:

Resolved, That Resolution No. 4 be referred to the Committee on Delivery of Health Services for further study and recommendation.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 9—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY VD & DRUG ABUSE EDUCATION COMBINED WITH REALISTIC EDUCATION ON HUMAN SEXUALITY

"*Resolved,* That the Iowa Medical Society re-affirm its stand in the three areas of VD, drug abuse and sex education, and be it further

"*Resolved,* That institutions of higher education be urged to engage in preparation of teachers who are able to cope with these problems, and at the same time, establish health education workshops for both teachers and lay individuals who are interested in becoming involved in such programs."

The Reference Committee agrees in substance with the resolution that we are in favor of eradicating venereal disease and ridding the community of the drug abuse problem and of furthering sex education, but we do not believe it is our place to deliver mandates to educational institutions in areas where they are already functioning.

RECOMMENDATION: *Resolved,* Resolution No. 9 be not adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 10—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY
ACTS OF VIOLENCE PORTRAYED ON TV

"*Resolved,* That the Iowa Medical Society go on record as condemning such permissiveness as deleterious to the moral education of our youth, and therefore be it further

"*Resolved,* That when such exposure is an integral part of the development of the plot and/or course of disintegration or regeneration of character, it has good educational and enlightenment value and should be used as such, and therefore be it further

"*Resolved,* That the NEA and AMA in their national meetings propose means by which such measures of 'Preventive Medicine' can be perpetrated on the viewing public as part of remedial therapy."

The Reference Committee finds in review of the Resolution No. 10 that this subject has already been covered in the Principles of Medical Ethics, Section 10, "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well being of the individual and the community."

RECOMMENDATION: *Resolved,* That Resolution No. 10 be not adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 8—INTRODUCED BY THE DUBUQUE COUNTY MEDICAL SOCIETY
MEDICAL CARE IN CORRECTIONAL INSTITUTIONS

"*Resolved,* That the Iowa Medical Society appoint a committee to investigate the quality of medical care at the correctional institutions in the State of Iowa and make any appropriate recommendations that might be indicated by its findings."

Based on discussions during the hearing, your Reference Committee believes attention should be given to the quality of care in correctional institutions. It was brought to the Committee's attention that several problems exist, not only in the realm of quality of care but also in the medico-legal area.

Your Reference Committee received much valuable information regarding medical care in correctional institutions. We are aware that there may be difficulty in obtaining medical services in such facilities. Among several problems cited, the most important may be that of adequate malpractice coverage for involved physicians. Malpractice insurers have refused to cover physicians serving patients in correctional institutions and the State of Iowa has refused to insure them unless they are full-time state employees.

RECOMMENDATION: *Resolved,* That the President of the Iowa Medical Society appoint a special committee to investigate the quality of medical care at the correctional institutions in the State of Iowa and make any appropriate recommendations to the House of Delegates that might be indicated by its findings.

Mr. Speaker, I move the adoption of the foregoing resolution.

SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

Your Reference Committee commends George L. Baker, M.D. and his committee for tackling a most difficult job. As you all know, the U. S. Supreme Court recently issued a decision dealing with the right of a mother to obtain termination of pregnancy. By virtue of the Supreme Court decision the burden of establishing procedural guidelines rests with the medical profession. The Subcommittee on Maternal and Child Health, drawing on material approved by the American College of Obstetricians and Gynecologists, and in collaboration with officials at the University of Iowa College of Medicine, has submitted a proposed statement for approval by the 1973 House of Delegates. Your Reference Committee is in agreement with the proposed statement but recommends that the House of Delegates reaffirm that portion of the Iowa Medical Society's position on termination of pregnancy taken by the 1970 House of Delegates, which is pertinent and relative to the Supreme Court decision.

RECOMMENDATION: "*Resolved,* That the Iowa Medical Society be on record in favor of new legislation that would leave the matter of the termination of a pregnancy between the woman and her physician.

"*Resolved,* That such legislation be in accordance with the following guidelines: (1) The termination of a pregnancy shall only be performed by a physician and surgeon licensed to practice in the State of Iowa; (2) No physician, hospital or hospital personnel shall be required to participate in the termination of a pregnancy; (3) Provisions shall be made so that no legal action can be taken against any hospital or person refusing to administer services relating to these procedures."

Mr. Speaker, I move the adoption of the foregoing resolution.

The Reference Committee has reviewed in depth the following recommendations of the Supplemental report of the Subcommittee on Maternal and Child Health, as amended by the Reference Committee.

"Pregnancy termination is a surgical procedure. For its performance adequate facilities, equipment and personnel are required to assure the highest standards of patient care. Pregnancy termination should be performed only by physicians who are qualified to identify and manage the complications that arise from the procedure.

"First trimester abortions (up to 12 weeks gestational age) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State Department of Health.

"Pregnancy termination beyond the first trimester should be performed in a hospital. It is hoped that the majority of terminations of pregnancy would be done under 12 weeks and only a limited number between the 12th and 20th weeks.

"From the end of the 20th week until the onset of fetal viability (normally between the 24th and 28th week) pregnancy termination would best be done only for medical or genetic indications. Beyond the period of viability termination should be subject to the approval of a Hospital Termination of Pregnancy Committee and only when the action based upon appropriate judgment is necessary for the preservation of the life or health of the pregnant woman.

"Facilities for the performance of first trimester terminations should include appropriate surgical, anesthetic and resuscitation equipment. In addition the following should be provided:

"1. Verification of the diagnosis and duration of pregnancy.

"2. Preoperative instructions and counselling.

"3. Recorded preoperative history and physical examination, particularly directed to identification of pre-existing or concurrent illness or drug sensitivity that may have a bearing on the operative procedures or the anesthesia.

"4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.

"5. Prevention of Rh sensitization.

"6. A receiving facility where the patient may be prepared and receive preoperative medication and observation prior to the procedure.

"7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.

"8. Postoperative instructions and arrangements for followup, including family planning advice.

"9. Reporting of legal induced abortions is essential. The State Department of Health should assume the responsibility for collection of the necessary data and preservation of the confidentiality of such information.

"It is recognized that termination of pregnancy may be performed at a patient's request or upon a physician's recommendation. *No physician or supporting personnel, or hospital or other facility should be required to perform or assist in the termination of pregnancy procedures;* nor should any patient be forced to accept termination of pregnancy.

"The usual informed consent, including operative permit, should be obtained. A patient who is married or 19 years of age (18 years of age effective July 1, 1973) may give her own consent. For other patients consent must be given by parent or legal guardian.

"It is important that the provision of abortion services not interfere with the care of other obstetric-gynecologic patients or with residency training programs in obstetrics and gynecology. Consideration should be given by hospitals to providing facilities where termination of pregnancy can be performed with minimal disruption of other hospital function."

Mr. Speaker, I move the adoption of the foregoing guidelines for the termination of pregnancy, as amended. (The italicized sentence represents that portion of the guidelines amended by the Reference Committee.)

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

Your Reference Committee has reviewed the excellent in-depth report of the Committee on Legislation which has clearly delineated the legislative history of the Iowa Medical Society and its present status. The Reference Committee received much wholesome discussion and many recommendations at its meeting which has guided its deliberations. We, and society in general, have entered a new era of consumer interest where we may experience some special problems. Society is evidencing a struggle within its people who are demanding "good medical services" but at the same time demanding a voice that will be heard in control of these services about which they may or may not be knowledgeable.

We recommend that the Legislative Committee re-evaluate its priorities, in light of this new social era, which must recognize the position of consumer involvement.

It is essential for the IMS to recognize the need to adapt to changing times and philosophies so as to assure that the best medical services are provided for the people of Iowa.

To accomplish this primary goal, your Reference Committee recommends that the Committee on Legislation coordinate the legislative activities and interests of IMPAC, the Iowa Academy of Family Physicians, various specialty groups, IMS Ladies Auxiliary, the Legislative Contact Men and others who have an interest in promoting the best medical services for Iowans. Your Reference Committee further recommends that the Committee on Legislation assume a more aggressive educational function and be readily available to disseminate informational material to all interested people.

We commend the Society for its excellent continuity of lobbyists, in spite of several changes, and we are especially impressed with the effectiveness of our present lobbyist, Mr. Rick Phillips.

We suggest that the Committee on Legislation place more emphasis than in the past, on state legislative activities.

Your Reference Committee recognizes the fact that legislative activities require adequate funding to be effective. We recommend that funding be assured for legislative functions that will best assure quality medical services for Iowans.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution:

Resolved, That the foregoing recommendations be adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

Your Reference Committee was fortunate to have AMA staff present to review the Medicredit proposal of the AMA. We recommend official IMS support of Medicredit with instructions that all Iowa Congressmen be promptly informed of this endorsement.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution:

Resolved, That the Iowa Medical Society officially endorse the Medicredit bill.

Mr. Speaker, I move the adoption of the foregoing resolution.

Mr. Speaker, this concludes the report of the Reference Committee on Legislation and Miscellaneous Business.

Respectfully submitted,
G. R. CLARK, M.D., *Chairman*
C. P. HAWKINS, M.D.
T. E. KIERNAN, M.D.
J. E. MCGILL, M.D.
S. A. SMITH, M.D.

INSURANCE AND MEDICAL SERVICE

The Reference Committee on Insurance and Medical Service met in open session at 8 a.m., Sunday, April 29, 1973. A large number of physicians were present for the session and participated freely in the discussion.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES— SECTION III, BLUE SHIELD REMARKS OF S. P. LEINBACH, M.D., CHAIRMAN, BLUE SHIELD BOARD OF DIRECTORS

The Reference Committee is pleased to find that the

Board of Trustees continues to maintain active liaison with Blue Shield. The House of Delegates has often expressed its support and encouragement of a close working relationship between the two organizations. The remarks of the Chairman of the Blue Shield Board of Directors reflect the importance of this liaison. The Reference Committee takes special note of the fifth anniversary of the joint IMS/BS field program. Several comments were offered in open hearing regarding the excellent service this program provides both organizations.

RECOMMENDATION: *Resolved,* That the Board of Trustees be commended for its efforts in maintaining an excellent rapport with Blue Shield officials and that it be encouraged to strengthen the Blue Shield programs in cooperation with the Blue Shield Board of Directors.

Mr. Speaker, I move the adoption of the foregoing resolution.

The Reference Committee was shown statistics which demonstrate that Blue Shield continues to convert the low level contracts to UCR as requested by the House of Delegates. As asked by the 1972 House of Delegates, Blue Shield has continued to explore possible methods of modifying the "prior agreement" and "hold harmless" interpretations within the UCR contract. As is true for all Blue Shield programs, its contracts must receive approval by the Iowa Insurance Commissioner. The Commissioner has denied the request to remove a "hold harmless" provision from the contract. The Reference Committee believes this may not be of major significance since UCR now reimburses approximately 95% of physician charges as submitted and utilizes the peer review program of the Iowa Foundation for Medical Care when any question arises on a Blue Shield payment.

One other item which should be pointed out to the House but requires no formal action relates to a request by the 1972 House of Delegates to see if benefits under Blue Shield could be assigned to a non-participating physician designated by a subscriber. In response the Insurance Commissioner declared: ". . . it is both possible and required by contract that claim payments involving participating physicians be paid directly to the physician. There is no legal basis, however, for payments made directly to non-participating physicians."

These last two subjects are called to the special attention of the House merely as matters of information and require no recommendation by the Reference Committee.

The Reference Committee heard comments that officials of Blue Cross-Blue Shield have on several occasions, met at the request of individual physicians and county medical societies to discuss the broad subject of "HMOs." The Iowa Medical Society, through past action, has encouraged Blue Shield to consider experimentation in the area of HMOs. The Reference Committee feels this activity should continue, but believes that county medical society officers should be kept fully apprised.

RECOMMENDATION: *Resolved,* That officials of Blue Cross and Blue Shield plus other third parties and organizations, be encouraged to notify officers of the appropriate county medical society when they are asked to meet with physicians at a local level to discuss Health Maintenance Organizations.

Mr. Speaker, I move the adoption of the foregoing resolution.

★

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SUPPLEMENTAL REPORT OF THE
SUBCOMMITTEE ON MEDICAL REVIEW
RESOLUTION NO. 14—INTRODUCED BY THE
POLK COUNTY MEDICAL SOCIETY
BLUE SHIELD

The Reference Committee considered these items jointly since they deal with the same general subject.

The Reference Committee recognizes the problems inherent in the present geographical breakdown of the state for determination of customary charges since these geographical regions do not correspond to the existing peer review districts. The Reference Committee agrees with the concept approved by the Subcommittee on Medical Review and the Iowa Foundation for Medical Care in support of a statewide customary charge profile by specialty, but recognizes that accomplishment of that goal may be difficult and may require some time to implement.

The Reference Committee acknowledges the uniqueness of the University Complex in Iowa City and believes that any statewide determination of customary charges would still require special consideration for the University Complex. This special consideration should not apply to the outreach satellite programs of the University Medical School located in communities outside of Iowa City.

RECOMMENDATION: *Resolved*, that the Subcommittee on Medical Review, in consultation with the Iowa Foundation for Medical Care, be encouraged to continue consideration of a "statewide customary profile" by specialty for implementation when deemed appropriate.

Mr. Speaker, I move the adoption of the foregoing resolution.

Resolution No. 14 from Polk County Medical Society dealt with this general topic but suggested a "fee schedule" in contrast to a UCR determination. The Reference Committee feels that in view of its foregoing recommendation that this resolution should not be approved.

RECOMMENDATION: *Resolved*, That Resolution No. 14 submitted by the Polk County Medical Society suggesting consideration of a statewide fee schedule be rejected.

Mr. Speaker, I move adoption of the foregoing resolution.

SUPPLEMENTAL REPORT OF THE
SUBCOMMITTEE ON COMPONENT BILLING
RESOLUTION NO. 11—INTRODUCED BY THE
POLK COUNTY MEDICAL SOCIETY
SURGICAL FEES

The bulk of testimony before the Reference Committee on the five component billing system was in support of its continued use where and when applicable. The Reference Committee is of the opinion that most objections to the concept of component billing relate to a lack of understanding of its function.

RECOMMENDATION: *Resolved*, That the five component billing system continue to be followed where and when applicable, and be it further

Resolved, That the special Committee on Component Billing be discharged and any further consideration on this subject be referred to an appropriate existing committee of the Iowa Medical Society.

Mr. Speaker, I move the adoption of the foregoing resolution.

Those speaking to Polk County Resolution No. 11 seemed to more fully understand the component billing concept as debate progressed. The Reference Committee agrees that there does not seem to be pressure exerted for physicians to change their method of billing. It was made very clear to the Reference Committee that the Iowa Medical Society is not suggesting that physicians divide or fragment their fees in any unethical or unacceptable manner.

RECOMMENDATION: *Resolved*, That Resolution No. 11 submitted by the Polk County Medical Society on Surgical fees be rejected.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 1—INTRODUCED BY THE
PAGE COUNTY MEDICAL SOCIETY
ADOPTION OF CURRENT
PROCEDURAL TERMINOLOGY

The Reference Committee is well aware of the debate being conducted nationally with regard to the adoption of a uniform nomenclature and coding system. Several state medical societies, specialty organizations and the American Medical Association have formulated coding and nomenclature guidelines. The Reference Committee feels the advantages of one acceptable coding and nomenclature system are quite evident, particularly if a physician could properly code and describe his services at the time a claim is submitted for payment rather than relying on personnel within the office of a third party. The Reference Committee recognizes that support of the AMA's CPT manual may not result in immediate implementation by Iowa Blue Shield or other third parties, however, the Reference Committee does agree that Resolution No. 1 should be adopted.

RECOMMENDATION: *Resolved*, That the Iowa Medical Society adopt and recommend that all members use the five digit system as described in the current procedural terminology.

Mr. Speaker, I move the adoption of Resolution No. 1.

RESOLUTION NO. 15—INTRODUCED BY THE
POCAHONTAS COUNTY MEDICAL SOCIETY
CONFIDENTIALITY OF
PHYSICIAN'S HOSPITAL RECORDS

The Reference Committee heard testimony from legal counsel on the existing law both state and national, relating to the release of information from patients' medical records. It is quite apparent to the Reference Committee that almost all third parties, both governmental and private, require at the time of enrollment consent by the participant to the release of any medical information that might be required for the proper adjudication of a claim. The patient has therefore given prior consent although many physicians would question whether or not the patient is fully aware of the consent he has given and if this would truly represent "informed consent."

Legal counsel further elaborated on the differences between availability of hospital records versus a physician's office records. Although the Reference Committee is in sympathy with the intent of the Resolution, they believe there is no legal basis for its adoption.

RECOMMENDATION: *Resolved*, That Resolution No. 15 from the Pocahontas County Medical Society relating to the confidentiality of physician and hospital records be rejected.

Mr. Speaker, I move adoption of the foregoing resolution.

RESOLUTION NO. 16—INTRODUCED BY THE POCAHONTAS COUNTY MEDICAL SOCIETY
NEW GUIDELINES FOR HEW FAMILY PLANNING PROJECTS

The Reference Committee recognizes that many governmental programs are administered without full consultation with and approval by organized medicine either at the local or state level. This lack of consultation with the medical profession may result in programs which provide services without respect to a person's income, payment on a fixed fee basis and including other guidelines which are objectionable to physicians. The Reference Committee was informed that the Iowa Medical Society has earlier received complaints regarding Family Planning projects administered through OEO and inquiries were instituted to determine if changes could be made, but with no apparent results.

RECOMMENDATION: The Reference Committee recommends the adoption of the resolved portion of Resolution No. 16 with some minor editorial changes.

Resolved, That the Iowa Medical Society protest the invasion of the private practice of medicine as reflected in certain "family planning projects" and encourage physicians to use the "usual and customary" fee principle and to continue to specify laboratories of their choice.

Mr. Speaker, I move adoption of the foregoing resolution.

Mr. Speaker, this concludes the report of the Reference Committee on Insurance and Medical Service.

Respectfully submitted,
P. M. SEEBOHM, M.D., *Chairman*
JAMES GANNON, M.D.
R. S. GERARD, M.D.
D. C. YOUNG, M.D.

ARTICLES OF INCORPORATION & BY-LAWS

The Reference Committee on Articles of Incorporation and By-Laws met in open hearing at 8:10 a.m., on Sunday, April 29, 1973, to consider the matters assigned to it. The approximately 50 physicians who participated in the three-hour discussion are to be complimented for their attendance at this early hour session, and they are to be commended for sharing much valuable opinion and information with the Reference Committee.

The Reference Committee recognizes that proposals to amend the Articles of Incorporation and By-Laws are submitted through the Standing Committee. This report is prepared in line with that provision.

For purposes of the record, the Reference Committee reminds the House of Delegates that action relating to the proposal submitted by the Standing Committee having to do with the number of alternate delegates to AMA was taken at the opening session on April 28, and therefore is in need only of implementing action as set forth at the close of this report.

Following are the recommendations which have been evolved by the Reference Committee based on its evaluation of the testimony presented.

SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION & BY-LAWS
SECTION I—JUDICIAL COUNCIL
MINIMUM ATTENDANCE REQUIREMENTS

The Reference Committee relays to the House the

DIRECTOR of MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

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unanimous feeling of those who offered testimony that active participation by the district councilors is all important if the Iowa Medical Society is to have a well informed and responsive membership. For this reason the Reference Committee is in support of the new language which has been devised and offered by the Standing Committee.

RECOMMENDATION: Mr. Speaker, the Reference Committee recommends adoption of the following resolution:

Resolved, That Article IV, Section 15 be amended by adding the following at the end of the first paragraph of said Section 15:

"Also, a vacancy in his office shall automatically be created if any Councilor, who has been a Councilor for the period beginning with the last day of an annual meeting and ending on the day preceding the last day of the next succeeding annual meeting, shall fail, without excuse acceptable to the Judicial Council, to attend sixty per cent of the meetings of the Judicial Council held during such period. The Judicial Council shall promptly notify the component society or societies comprising that Councilor's district of the vacancy in his office."

Mr. Speaker, I move the adoption of this Resolution.

RESOLUTION NO. 7—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY LIFE MEMBERSHIP

Even though representatives of the sponsoring county medical society did not present testimony on this resolution, its intent struck a responsive chord with the Reference Committee. Recognizing that in today's mobile society movement from one state to another is quite commonplace, the Reference Committee believes that long service to the practice of medicine deserves appropriate recognition by the profession. The current stipulation for Life Membership requires a physician to practice medicine 50 years and be a member of this Society for 30 years. This second requirement for Life Membership in the Society is regarded as excessive by the Reference Committee. The resolution submitted by Black Hawk County suggests a change to 40 years in the active practice of medicine and 40 years of Society membership; the logic for this suggestion is not known.

RECOMMENDATION: The Reference Committee recommends the adoption of the following substitute resolution in lieu of Resolution No. 7:

Resolved, That the Standing Committee on Articles of Incorporation and By-Laws be requested to develop appropriate language modifying the Articles of Incorporation and By-Laws to provide for Life Membership after a physician has practiced medicine for 50 years and has been a member of this Society for the last 15 consecutive years, and to submit said language at the next meeting of the House of Delegates.

Mr. Speaker, I move the adoption of this Resolution.

RESOLUTION NO. 2—INTRODUCED BY THE MARION COUNTY MEDICAL SOCIETY REVISED MEMBERSHIP TENURE FOR ELECTION TO OFFICE IN IMS

The authors of this resolution which would eliminate the requirement of five years membership in the Society as a prerequisite to holding office presented their thoughts in an effective manner. In the discussion which ensued it was generally agreed this stipulation is excessive. However, most of those who spoke to the subject, including the sponsors, reached the conclusion that some interval of membership is appropriate in advance of holding a Society office.

RECOMMENDATION: Based on the discussion which occurred, and with the presumed acceptance and endorsement of the Marion County Medical Society, the Reference Committee recommends the adoption of the following substitute Resolution:

Resolved, That the Standing Committee on Articles of Incorporation and By-Laws be instructed to draft appropriate language modifying the Articles of Incorporation and By-Laws to require a period of two years' membership before a physician shall be entitled to hold an office in the Iowa Medical Society, and to submit said language at the next meeting of the House of Delegates.

Mr. Speaker, I move the adoption of this substitute Resolution.

HANDBOOK REPORT OF COMMITTEE ON HOUSE OF DELEGATES APPORTIONMENT

The Reference Committee is much impressed by the effective work which has been accomplished by the Ad Hoc Committee on House of Delegates Apportionment. The evaluation made by the Ad Hoc Committee of this crucial and complex area has been time consuming and has involved extensive research.

(1) SECTION ON NOMINATING COMMITTEE

The Reference Committee has noted the review which has been made of the functions of the Nominating Committee and is of the opinion the measures which have been instituted this year have increased the effectiveness of the Society in this important area.

RECOMMENDATION: The Reference Committee believes the recent effort to improve this vital aspect of the Society's democratic process deserves commendation and continued attention.

Mr. Speaker, I move the adoption of this recommendation.

(2) SECTION ON SPECIALTY REPRESENTATION IN THE HOUSE OF DELEGATES

The Reference Committee was interested in noting the statistics developed by the Ad Hoc Committee which demonstrate a proportional distribution among the specialty groups within the House of Delegates.

RECOMMENDATION: The Reference Committee concurs that no change should be made in the House of Delegates in terms of specialty representation.

Mr. Speaker, I move the adoption of this recommendation.

(3) HOUSE OF DELEGATES REAPPORTIONMENT

That there has been and will be much ferment over this subject is acknowledged by the Reference Committee. As mentioned previously, the Reference Committee is much impressed by the efforts of the Ad Hoc Committee to find a new means of promoting and assuring broad and effective representation by the medical profession in the House of Delegates.

The Reference Committee finds itself holding to the opinion that success in terms of Society performance will be in direct relation to local initiative and local leadership, regardless of whether local is represented by a county or district.

It appears to the Reference Committee that much of the reluctance to consider seriously structural changes in the House of Delegates derives from those areas

where the leadership has not reached its appropriate potential.

Thus, it is the feeling of the Reference Committee that an updating of the organization of the House of Delegates, as proposed by the Ad Hoc Committee, may be the catalyst necessary to stimulate the medical profession in Iowa to pursue with new vigor those important scientific and socio-economic matters that will deserve our maximum attention in the years just ahead.

RECOMMENDATION: The Reference Committee submits the following resolution:

Resolved, That the following language from the report of the Ad Hoc Committee (with the italicized words added for clarity and emphasis by the Reference Committee) be referred to the Standing Committee on Articles of Incorporation and By-Laws, and that it be instructed to prepare the necessary implementing language for presentation at a Regular Meeting of the House of Delegates in the Fall:

"1) The present number of councilor districts (12) should be retained. However, in order to achieve a more equal proportion of members in each district, the present councilor districts should be realigned. This could be accomplished without an amendment to the Articles and By-Laws and could be achieved by a simple action of the House of Delegates. The suggested realignment of districts is illustrated in the attached map. (See Attachment #3 on page 324.) It is recognized that a county medical society for various reasons may want to be in a different district than the one recommended. Final geographic boundaries would be up to the House of Delegates but the Committee believes it essential that all districts be compact (contiguous) and not unduly disproportionate in doctor population.

"2) Each *councilor* district would be allowed to elect one delegate for each 15 members or *major* fraction thereof in the district. In order to assure that the smaller counties have the opportunity to be represented in the House, it is further recommended that the following provisions be made:

"a) Each *county* shall be able to elect from its membership no more than its proportionate share of the total number of delegates in the *councilor* district.

"b) If a county does not have within its boundaries the 15 members necessary to secure a delegate's seat, that county may combine with another county *(or counties)* for the purposes of electing a delegate. "Under the plan, every component society or combination thereof whose membership is 15 or more shall be able to elect a delegate if it chooses to do so. In addition, each component society has the opportunity to nominate physicians to run as delegates at large."

(After extensive discussion of this portion of the Reference Committee Report dealing with reapportionment of the House of Delegates, a motion to refer the material in quotes to the Standing Committee on Articles of Incorporation and By-Laws was passed by a vote of 49 ayes to 47 nays.)

And be it further,

Resolved, That in line with the foregoing, the Society use the interval between now and the next meeting of the House of Delegates, to bring to the attention of the general membership by various means, e.g., mailings, regional meetings, councilor contacts, etc., the mechanics and implications of this proposal and invite for the benefit of the delegates who will be voting on the measure this Fall as much grass roots reaction as possible.

Mr. Speaker, I move the adoption of this Resolution.

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RESOLUTION NO. 12—INTRODUCED BY THE POLK COUNTY MEDICAL SOCIETY REAPPORTIONMENT OF DELEGATES TO IOWA MEDICAL SCCIETY

This resolution recommends that delegates to the House of Delegates be chosen on the basis of one delegate for every 25 members or major fraction thereof within a Councilor District.

The Reference Committee is of the opinion that Polk County finds the recommendations contained in the Ad Hoc Committee Report and embodied in the preceding resolutions to fulfill those purposes intended by its resolution and is willing therefore to have the matter pursued in this way.

RECOMMENDATION: The Reference Committee recommends that Resolution No. 12 be disapproved.

Mr. Speaker, I move the adoption of this recommendation.

RECOMMENDATION: The Reference Committee further proposes the following:

Resolved, That the Chairman of the Board of Trustees and the Secretary of Iowa Medical Society be and they hereby are authorized and directed to sign, acknowledge and publish the Amendments, adopted by the House of Delegates at this meeting, as the Thirteenth Amendments to the Articles of Incorporation, as amended, and to do all other things required by law or otherwise to execute, complete and place in lawful effect such Amendments.

Mr. Speaker, I move the adoption of the foregoing Resolution.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws.

Respectfully submitted,
L. J. O'BRIEN, M.D., *Chairman*
F. M. ASHLER, M.D.
D. A. BOVENMYER, M.D.
G. T. SCHMUNK, M.D.
W. T. SHULTZ, M.D.

Following recognition of members of Reference Committees, Dr. R. L. Wicks, President, Scanlon Medical Foundation/Iowa Medical Society, urged the delegates to complete Foundation pledge cards placed at their seats. Dr. Wicks asked for the delegates' assistance in finding funds for those medical students who will be seeking Foundation loans. Dr. Wicks expressed gratification for the opportunity to associate with the student loan recipients and stressed the importance of the Scanlon Foundation program.

The Speaker then asked if there was any new business to come before the House. Dr. Schlaser read an invitation extended by Polk County Medical Society to have the IMS Annual Meeting in Des Moines in 1975. He then moved that the House of Delegates approve the actions of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, worded as follows, was seconded and adopted:

Resolved, That the action of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting to the present be and hereby are ratified and confirmed.

Dr. Schlaser continued: "Mr. Speaker, I have the pleasant task of offering another motion to the House of Delegates. One could introduce this motion by a lengthy, laudatory statement, but I simply want to say personally, and on behalf of the other officers of the Society, how much we have enjoyed working with our president, Dr. Kenneth Lister. I am sure this opinion is shared by this House of Delegates, and it has already been expressed." The commendatory motion by Dr. Schlaser was approved by applause and a standing ovation.

Dr. Caraway then announced an organizational meeting of the Board of Trustees would be held immediately following the adjournment of the House of Delegates, and the organizational meeting of the Judicial Council would occur at that time, too. He also informed the delegates that the installation of the new IMS president would occur after formal adjournment of the House and prior to those other two meetings.

Dr. John Sunderbruch, President, Iowa Foundation for Medical Care, urged and invited every member of the Iowa Medical Society and every doctor in Iowa, to join the Iowa Foundation for Medical Care.

Official dates of the next meeting of House of Delegates were announced by Mr. Donald L. Taylor, Executive Vice President, as October 12, 13 and 14, 1973.

Following his installation as new IMS president, Dr. R. H. Flocks told the delegates his prime purpose would be "to give the people of Iowa the best that medicine can."

The House of Delegates was adjourned at 11:50 a.m.

A 1973 REGULAR SESSION OF THE
IOWA MEDICAL SOCIETY
HOUSE OF DELEGATES
WILL OCCUR
OCTOBER 12-14, 1973
AT THE
FORT DES MOINES HOTEL

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Vice Speaker of the House of Delegates
Robert D. Whinery, Iowa City

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	Term Expires
First District, Clarkson L. Kelly, Jr., Charles City	1976
Second District, Harry G. Marinos, Mason City	1974
Third District, John M. Rhodes, Pocahontas	1975
Fourth District, Daniel M. Youngblade, Sioux City	1976
Fifth District, Clarence H. Denser, Jr., Des Moines	1975
Sixth District, Albert M. Dolan, Waterloo	1976
Seventh District, John E. Tyrrell, Manchester, Secretary	1974
Eighth District, John F. Collins, Davenport	1974
Ninth District, Keith A. Garber, Corydon	1974
Tenth District, Elmo E. Gamet, Lamoni, Chairman	1975
Eleventh District, Hormoz Rassekh, Council Bluffs	1976
Twelfth District, Enfred E. Linder, Ogden	1974

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Jerome F. Paulson, Mason City	1975
Al J. Havlik, Tama	1976

DELEGATES TO AMA

	Term Expires
Leslie W. Swanson, Mason City	December 31, 1974
Herman J. Smith, Des Moines	December 31, 1974
Elmer M. Smith, Des Moines	December 31, 1973

DELEGATES TO AMA (effective 1-1-74)

	Term Expires
Leslie W. Swanson, Mason City	December 31, 1974
Herman J. Smith, Des Moines	December 31, 1974
Christian E. Radcliffe, Iowa City	December 31, 1975

ALTERNATE DELEGATE TO AMA

	Term Expires
Christian E. Radcliffe, Iowa City	December 31, 1973

ALTERNATE DELEGATES TO AMA (effective 1-1-74)

	Term Expires
John R. Anderson, Boone	December 31, 1975
Erling Larson, Jr., Davenport	December 31, 1975
John M. Rhodes, Sr., Pocahontas	December 31, 1975

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Robert M. Chapman ..... Cedar Rapids
Verne L. Schlaser ..... Des Moines
Thomas A. Burcham ..... Des Moines
James F. Bishop ..... Davenport
Jerome F. Paulson ..... Mason City
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Clarkson L. Kelly, Jr. ..... Charles City
Harry G. Marinos ..... Mason City
John M. Rhodes ..... Pocahontas
Daniel M. Youngblade ..... Soux City
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John E. Tyrrell ..... Manchester
John F. Collins ..... Davenport
Keith A. Garber ..... Corydon
Elmo E. Gamet ..... Lamoni
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R. L. Wicks ..... Boone
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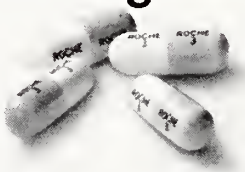
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands — of, say, ampicillin or tetracycline — or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

the Social Security Act. It will make determinations as to the medical need for care and assure the quality of care rendered meets professionally recognized standards.

The PSRO will at first review services provided in and by institutions, such as hospitals and extended care facilities. In this review, the PSRO must determine if care provided institutionally could have been, within the definition of good medical practice, rendered effectively and more economically on an out-patient basis or in a less expensive in-patient facility. Particular attention must be paid to the medical necessity of admission, the type and extent of services ordered in the institution, and the length of stay.

As mentioned, initial PSRO activity will be limited to the review of services provided institutionally. However, expansion of function is anticipated so that eventually all services rendered by health care practitioners and providers will come under its purview. Specific PSRO duties will include maintenance and regular review of patient and provider profiles, as well as the collection, maintenance and analysis of data pertinent to its various functions. By law, the PSRO must apply professionally-developed norms of care based on regional patterns of medical practice in its evaluation and review of services rendered in the area.

The physicians of Iowa, through the Executive Council of the Iowa Medical Society, have instructed the Iowa Foundation for Medical Care to seek PSRO designation for Iowa.

The Secretary of Health, Education and Welfare must designate PSRO areas throughout the country by January 1, 1974, and follow this by entering into conditional and eventually operational agreements with qualified organizations in these areas. In this process the new law affords priority to organizations which are non-profit, professional associations or component organizations composed of licensed and practicing doctors of medicine or osteopathy.

PSRO's will be organizations of most of the physicians practicing in a geographic area. If the physicians are assigned responsibility for reviewing hospital care, the law says they must have active staff privileges in at least one of the PSRO area participating hospitals.

One phase of PSRO which has now been implemented is the appointment of an 11-member National Professional Standards Review Council. This Council will be a policy body and will advise the HEW Secretary and Congress. It will oversee statewide councils' activities and generally aid the overall program.

Following for re-emphasis are salient points regarding PSRO:

- PSRO will involve physician evaluation of the appropriateness of patient care in hospitals and other institutions. This may take the form of evaluating (1) conditions prior to admission, (2) the care received during hospitalization, and (3) the length of hospitalization.
- Formation of a PSRO is expected to start at the local level. Local physicians (this has been interpreted to mean an entire state in certain circumstances) are to be responsible for the development and operation of the PSRO.
- PSRO is applicable to Medicare and Medicaid at this time.
- PSRO is not to deal with fees or charges.
- If a practicing physician organization with potential for developing a PSRO does not come forth by January 1, 1976, the HEW Secretary can designate a physician organization to serve.
- The first priority is the designation of PSRO areas; HEW must do this by January 1, 1974. It expects then to contact state medical societies, etc., those organizations identified as having an interest in or potential to develop a PSRO.
- The minimum number of physicians for a PSRO area has been noted as 300. A maximum has been mentioned of from 2,500 to 3,000 (this would accommodate Iowa).
- Norms of care will be developed locally by physicians. They will judge whether a colleague has met the locally established criteria.
- PSRO is justified on the basis that government is paying for a significant amount of medical care. It thus believes through PSRO it will be assured the care received is appropriate.

Oh, those PSRO clouds we spoke of earlier. Will they produce refreshing, beneficial rainfall? Or will they result in torrents to wash away much that is good and long standing? Time will tell.

State Department of Health

THE IOWA EMERGENCY MEDICAL SERVICES COMMUNICATIONS PLAN

In the January 1973 issue of the JOURNAL we described the status of emergency medical service communications in Iowa and the development of a state plan. The plan for an Iowa Emergency Medical Services Communications System (EMSCS) has now been completed by Spectra Associates, Inc., a Cedar Rapids communications consultant, and has been approved by the Governor's EMS Advisory Council. The plan is being implemented by the Iowa Department of Health with the participation of the Iowa Hospital Association and several other state and local agencies. Funds for development of the plan have come from the U. S. Department of Transportation through the National Highway Traffic Safety Administration.

The plan's primary objective is to provide a system standard for Emergency Medical Services Communications throughout Iowa and beyond its borders. The plan is integrated with disaster communications and with other emergency services. The plan identifies 20 regions in the State which have already coordinated their health and emergency planning efforts. The plan improves markedly on the procedures which now exist for requesting ambulance and rescue services. Standard radio equipment in ambulance and rescue vehicles is provided in the plan to allow communications between the vehicles and a central dispatcher. This plan will also permit direct communications with hospital emergency rooms and mutual-aid communications with law enforcement/public safety vehicles.

Regional Comm Center dispatchers must be trained to coordinate emergency service agencies, i.e., in providing intensive care, utilizing blood bank inventory, and in contacting specialists having skills beyond those available in a local community or a county. The regional Comm Centers must be able to communicate with participating medical facilities with reliable point-to-point radio links when telephone lines are inoperative.

FOR MORBIDITY REPORT
See Page 401

In each of the 20 regions the EMSCS has a single Comm Center to receive requests which arrive from any location within that region. In this way there is a uniform method for citizens and others to request assistance. And with a single Comm Center public and private agencies may report rapidly that a medical emergency exists and provide detail information on those who need treatment.

The Comm Center dispatcher has equipment to communicate quickly and directly with any ambulance operations center in the region and with the ambulance and rescue vehicles. The dispatcher is also able to communicate directly with all hospital emergency rooms. The system is devised so an ambulance may communicate via radio directly with participating hospital emergency rooms whether they have radio or not. A direct communication may be moved from the ambulance through the Comm Center via telephone lines to a hospital emergency room when there is no radio equipment. The

advantage here is that all hospitals providing emergency services need not maintain a radio base station.

The Comm Center dispatcher will have at his disposal an inventory of all regional ambulance and rescue units, and he will maintain an active record of their status. The dispatcher will be able to communicate directly with various governmental and public safety agencies within a region to secure the services which these agencies can provide in various emergencies.

The Comm Center dispatcher is required in each emergency situation to make accurate and rapid decisions. Thus the individual must be well trained in medical terminology and emergency practices and have a precise knowledge of all the capabilities for emergency assistance in the region.

The development of each of the 20 Comm Centers can be most economically achieved by expansion of an existing manned communications facility. The Comm Center facility choices in order of preference, recognizing present and future activity, are:

1. Hospitals with a hospital based ambulance service.

2. Area hospitals with a strong emergency medical capability and an ability and willingness to be responsible for an EMS Comm Center within a region.

3. Local government agencies willing to allow a cooperative use of their existing Comm Centers for regional activities. These may be law enforcement, fire department or ambulance/rescue agencies.

4. In certain larger communities, a private or public ambulance operation may be able to provide the communications center function, providing there is a sufficiently viable economic base for long term activity and regional responsibility.

A cooperative effort must be made among the many agencies in each region to establish an operating system in accordance with the plan. It must then be operated in a responsible manner. The most important step is establishment of the required Comm Centers. The second priority is the installation of ambulance vehicle radio systems in accordance with the plan. These priorities, when met, will allow communication between ambulances and hospital emergency rooms. The third essential is the establishment of a statewide telephone call system for uniform emergency request transfer to Comm Centers. A fourth priority is to equip hospitals or groups of hospitals with radio base stations when the communications activity of these hospitals is sufficient to justify a separate communication link between the ambulances and the hospitals' emergency rooms.

It is important for all physicians concerned with emergency medical care, hospital administrators and directors of emergency facilities, ambulance operators or supervisors and public safety agencies to become aware of the plan and cooperate in its regional implementation.

In summary the Emergency Medical Services Communications System Plan provides the following:

1. A system of 20 regions covering the entire state with one Comm Center located in each region.

2. A single well known telephone number statewide, calls to which are answered and transferred to the appropriate EMS Communication Center.

3. A trained dispatcher who assumes responsibility for efficient and appropriate action in handling of emergency requests for a region.

4. A central dispatch system for coordinating hospitals, ambulance, rescue vehicle and public safety activities throughout a region.

5. A communications network capable of providing direct communications links between hospitals or physicians and ambulance vehicles and for coordination of rescue units, ambulances, law enforcement agencies, ambulance service operations, doctors, fire departments, wrecker services, etc.

For further information regarding the plan contact your Area Health Planning Council, or for further information related to EMSCS regional planning contact: *Mr. Albert E. Hunter, Chief, Emergency Medical Service Section, State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319 (Telephone No. 515-281-3397).*

For discussion of communications system engineering contact: *Mr. L. M. Seiler, Division of Communications, Department of General Services, Grimes State Office Building, Des Moines, Iowa 50319 (Telephone No. 515-281-3120).*

SCIENTIFIC ARTICLES

The Syndrome of Angina Pectoris With Normal Coronary Arteriograms

RICHARD C. PEMBROOK, M.D.
Des Moines

In 1910 Sir William Osler first described angina pectoris in a young man who, at autopsy, was found to have normal coronary arteries.[1] Since then, both angiographic and autopsy studies have confirmed that transmural myocardial infarction without significant obstructive disease of the coronary arteries is extremely rare.[2-11] In general, clinical studies have confirmed the clinical impression that significant obstructive lesions occur in at least 2 coronary arteries in patients with angina and abnormal resting or post-exercise electrocardiograms.[12-15] However, over the past decade there has been increasing interest in the syndrome of angina pectoris with normal coronary arteriograms and no other cardiac disease.[16-24, 33]

This article will consists of a case presentation and a discussion of the clinical manifestations and possible etiologies.

CASE PRESENTATION

The patient is a 51-year-old Caucasian female who entered the Des Moines Veterans Administration Hospital for evaluation of chest pain. A diffuse "burning" retrosternal pain was described with radiation into the neck and jaws. Duration of the pain was about 20 minutes, but might remain in the jaw for 3 days after the chest pain had subsided. The patient became incapacitated with the recurrent episodes of pain. The patient smoked one pack of cigarettes per day until 2 weeks prior to admission. Her maternal aunt and uncle died of "heart trouble" in their seventies.

On physical examination the patient was normotensive. She had evidence of stasis pigmentation of the ankles, but otherwise her physical examination was normal.

A 4-hour glucose tolerance test was mildly abnormal with a one-hour blood sugar of 258. A serum cholesterol was 374. Serum triglycerides was 100. Serum lipoprotein electrophoresis showed an elevation of the beta fraction. Blood carboxyhemoglobin was .02% (normal up to 1.5%). Her oxygen-hemoglobin dissociation curve was normal. A treadmill electrocardiogram produced ischemic-type ST depressions after 3 minutes at 2 miles per hour on a 10% grade, although the patient did not experience chest pain.

On November 13, 1972, the patient underwent coronary angiography by the Judkin's

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THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST, 1973.

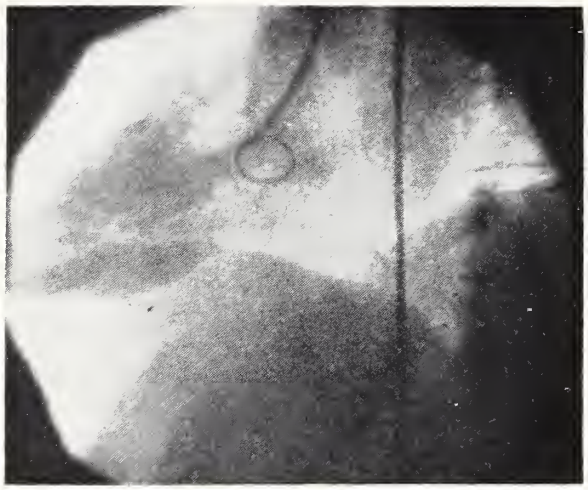


Figure 1. Left ventricular angiogram—end of diastole. 30 degree right anterior oblique position.

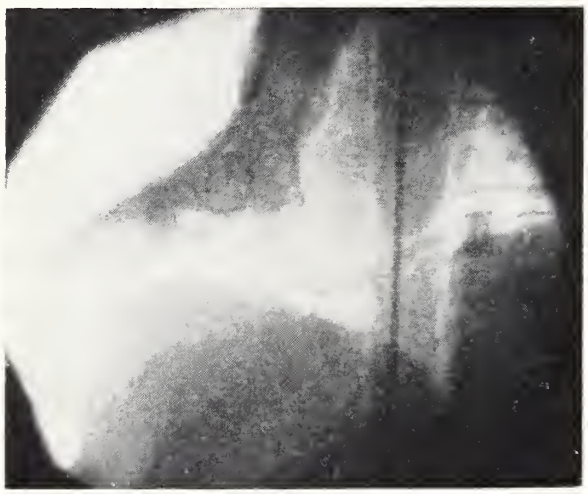


Figure 2. Left ventricular angiogram—end of systole. 30 degree right anterior oblique position.

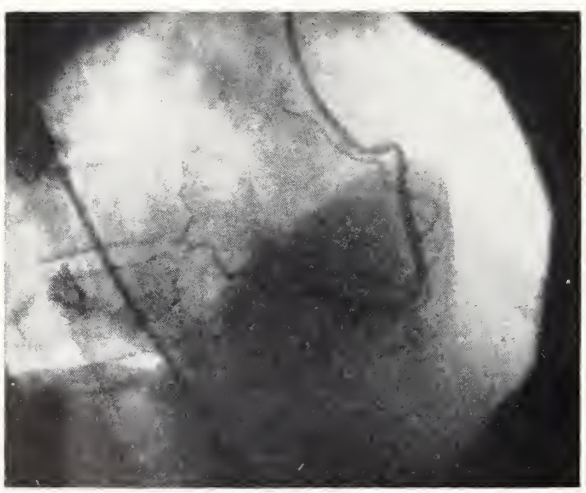


Figure 3. Right coronary artery. 60 degree left anterior oblique position.

technique. The patient had cineangiography with 9 cc of 76% Renografin in the 30 and 60 degree right and left anterior oblique positions, a total of 4 injections in each coronary artery. The patient had a 10-second period of asystole following the final injection which reverted to sinus rhythm following a single chest thump. The patient did not lose consciousness prior to reversion to sinus rhythm and had no residual effects. Review of the coronary cineangiograms revealed excellent visualization of a normal coronary tree (see illustrations). The left ventricular angiogram revealed excellent contractility with a high ejection fraction.

The patient had an episode of chest pain during the cineangiography which was not totally alleviated by nitroglycerine. The patient was discharged 4 days later on propranolol.

DISCUSSION

The clinical manifestations of this syndrome have varied in different reports. In most series there has been a predominance of female patients and in some series the patients were exclusively female,[14, 17, 20, 21, 23, 24] although there was a predominance of males in the series of Dwyer, *et al.*[16] Most patients were middle-aged. The pain tended to be more vaguely described than angina due to obstructive coronary disease and was less easily reproduced by a given quantity of exercise, but this difference was not helpful in the individual case.[20, 21, 25] There was a variable response to nitroglycerine or propranolol with most patients showing improvement, but some were actually made worse.[16, 20, 21, 25]

Physical examination was helpful only in excluding other causes of angina.[25] Hypercholesterolemia or hypertriglyceridemia was found in a minority of patients. Elevated fasting blood sugars or post-prandial blood sugars were found in a minority of patients, although many did not have glucose tolerance curves and none had a cortisone glucose tolerance curve. Resting or post-exercise electrocardiograms were usually abnormal and often showed apparent true ischemic changes.[25] In the group of Dwyer, *et al* there was an elevation of the left ventricular end-diastolic pressure with exercise.[16]

The prognosis appears to be much more favorable than that of a similar group with obstructive coronary disease, although several re-

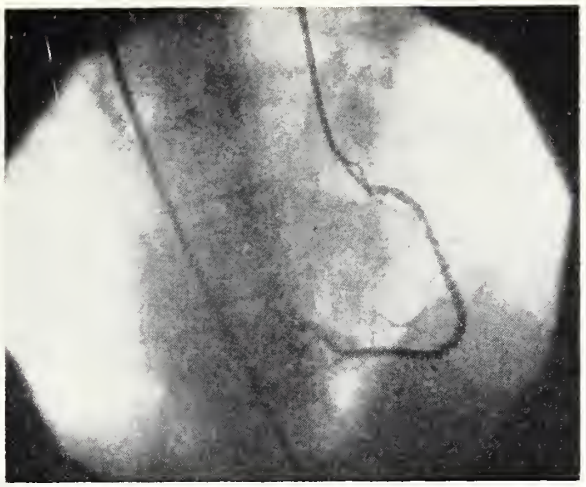


Figure 4. Right coronary artery. 30 degree left anterior oblique position.

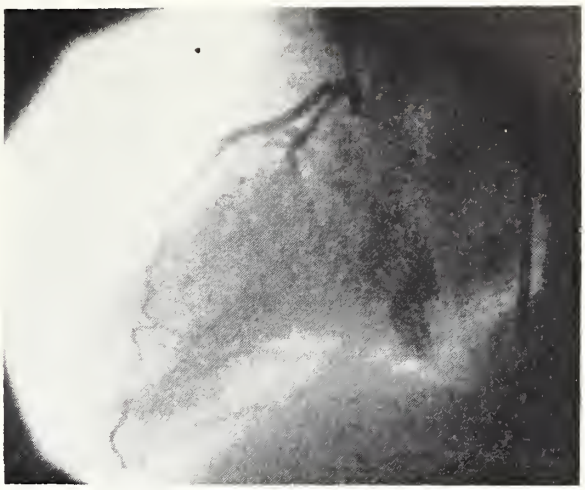


Figure 5. Left coronary artery. 60 degree right anterior oblique position.

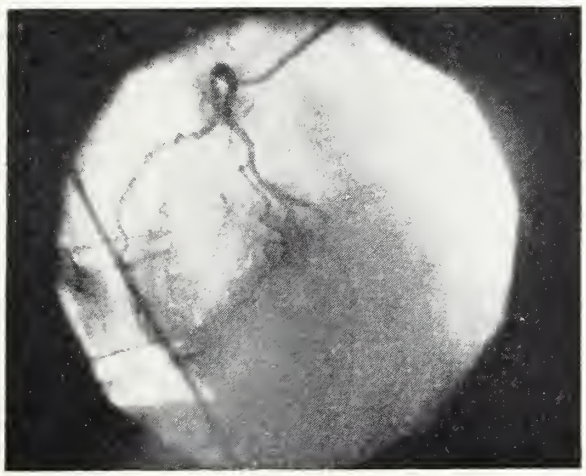


Figure 6. Left coronary artery. 60 degree left anterior oblique position.

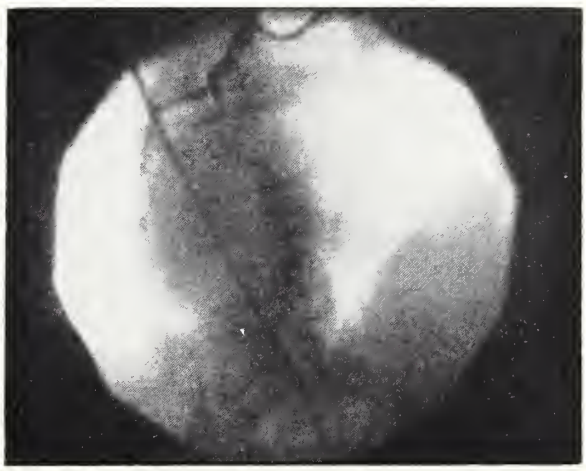


Figure 7. Left coronary artery. 30 degree left anterior oblique position.

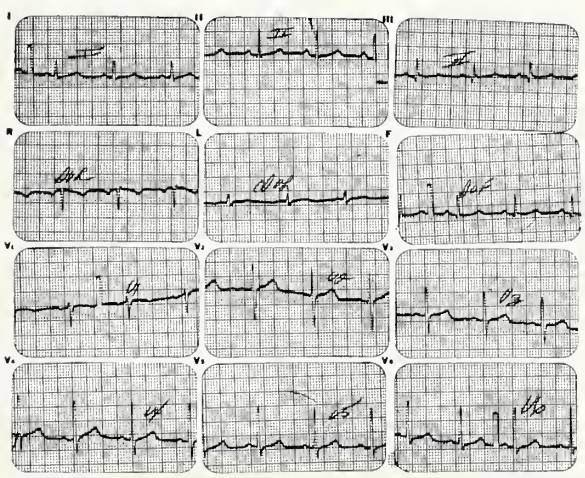


Figure 8. Electrocardiogram prior to treadmill.

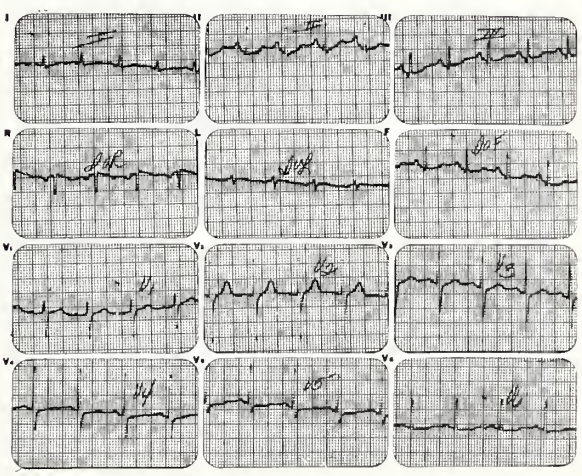


Figure 9. Electrocardiogram after 3 minutes at 3.0 mph on the treadmill at 10% grade.

ports of myocardial infarction and/or sudden death are noted.[16, 20, 21, 23–25] Abnormal myocardial lactate production has been demonstrated, thus documenting the existence of myocardial ischemia.[10, 22]

Various etiologies have been postulated for this syndrome. In the series of Eliot and Bratt all 15 patients had abnormal hemoglobin-oxygen dissociation curves[17]—so-called "stingy hemoglobin." All 15 were cigarette smokers and all had a normal hemoglobin-oxygen dissociation curve four weeks after stopping cigarettes. However, the patient of Neill, *et al* had a normal hemoglobin-oxygen dissociation curve. Furthermore many patients lost their angina despite continuing to smoke and many of the patients did not smoke.[25]

Coronary small vessel disease is known to occur in several neuromuscular diseases, but none of these diseases were present in any of these cases.[26, 27] It is known that in diabetes mellitus proliferative lesions of the intramural coronary branches occur.[26, 27, 28] Small vessel disease due to platelet aggregation has also been postulated.[20] However, documentation of this occurrence is lacking. Also, recently James has stated that small vessel disease is unlikely in the majority of patients with angina and normal coronary angiograms.[19]

Elevated carboxy-hemoglobin has also been postulated[29] but patients with far greater degrees of myocardial hypoxia due to blood loss or carbon monoxide poisoning frequently do not have angina.

The largest series in the literature (100) is by Waxler, *et al.* These authors favor a functional etiology.[25] This explanation would tend to explain the relatively favorable prognosis, but would do nothing to elucidate the underlying mechanisms.

It is known that in neurocirculatory asthenia there may be "ischemic" ST-T changes.[30] These may be abolished with potassium chloride infusions or Inderal therapy.[30, 31] Functional spasm of large coronary arteries has been documented as a cause of angina, but the relative frequency is not known.[10]

James thinks that error in interpretation of the angiogram is the biggest single source of this syndrome.[19] However, other authors feel this explanation is unlikely.[18, 20, 25]

Hyperventilation syndrome is known to cause "ischemic" type electrocardiographic changes.[32] Emotional instability has been reported by some authors.[25] Deficiency of LDH isoenzymes 1 and 2 was reported in one patient by Normand, *et al.*[24]

CONCLUSION

Our patient is representative of a syndrome characterized by chest pain and normal coronary angiograms. The patients with this syndrome tend to be middle-aged females who smoke. Objective documentation of myocardial ischemia has been obtained by demonstration of elevation of left ventricular end diastolic pressures after exercise and by elevation of cardiac venous lactate. Exercise electrocardiography tends to be positive. Some patients have had myocardial infarction, but the overall prognosis for life appears to be favorable. Most patients respond to therapy with Inderal or nitroglycerine, but some are refractory.

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The references noted in this article are available from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Sept. 13-15	Iowa Society of Anesthesiologists
Sept. 14-16	Third Annual Diologue for Physicions ond Haspital Administratars (Loke Okaboji)
Sept. 14-16	Reunion Meeting, Class of 1948
Sept. 19	Poge County Medicol Society (Shenandooh)
Sept. 19-20	Conference on Pediatrics
Sept. 21-22	Pastgraduote Conference in Uralogy
Sept. 24-27	Cordiology Today
Sept. 26	Deoling with Emergencies (Broodlowns Hospitol, Des Moines)
Sept. 26	Diet Therapy U.S.A.
Oct. 3	Whot's New in Strake?

Rural Family Counseling

JOSEPH F. VEVERKA, M.D., A.B.F.P., and
JAMES GOLDMAN, B.A., M.A., A.C.S.W.
Prairie City

MUCH HAS BEEN WRITTEN in recent years about family counseling. The problem, as the authors view it, is how to deliver this service in a rural area without compromising the family physician's effectiveness in other areas of need. The time factor alone has been enough to stop most physicians, without regard to their level of competence or their interest in handling the emotional problems of the community.

It is our belief most family physicians are interested and aware of the emotional needs of their patients but, for the preceding reasons, are unable to care for many. These factors prompted the authors to embark on an 11 month pilot project (or feasibility study) of family counseling in a rural area, utilizing the knowledge of a family physician with respect to the patient and his background, and the skill of a trained social worker. As far as we know, no such study involving a small rural community, a private solo physician, and a social worker has been published.

The attempt was made in this project to help those individuals functioning relatively well with their jobs and/or families but evidencing manifestations of stress sufficient enough to threaten their continuance of these functions. The project was not aimed at providing care for those who could be best served in a hospital setting under the guidance and ministrations of a psychiatrist.

COMMUNITY SETTING

The project was undertaken in a community with a population of 1,140. Its medical facility is the only one within an approximate radius of 20 miles except for one physician eight miles north and another nine miles southeast. Des Moines is approximately 20 miles west and Newton, 20 miles east. As will be noted, this encompasses a relatively wide area and obviously qualifies as a typical rural community.

The population in this area is mostly Caucasian, with some ties to a Northern European heritage. The people are conservative, religious, and belong to the middle income group.

METHOD

It was decided the counselor would be available on alternate Saturdays through the year. As will be noted later he was present 19 Saturdays. The reason for this (as opposed to 24) was due to vacations, scheduling conflicts, weather conditions, conventions, etc. Office space, secretarial help, billing, payment for a listing in the weekly Professional Directory in the local newspaper, etc., were supplied free of charge to the counselor. Payment was made by the patient directly to the counselor. The per patient fee was $15 for a 50 minute interview. The physician received no monetary compensation. The counselor provided his own malpractice insurance. He kept his own records but in all cases there was consultation between the counselor and the physician. This consultation was intended to assure continuity of care in the interim when the counselor was not present and also to guard against the possibility of organic illness creating the symptomatology.

With one exception all the patients interviewed came from the physician's practice and their physicial health was known. It was decided further that no effort would be made to develop a community or area referral system through the schools, clergy, clubs or other physicians. The only exception was the Professional Directory entry in the local newspaper. This limitation was imposed to heighten the accuracy of our reporting, over concern that the

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study might get out of hand from trying to serve too many patients in the limited time available, and finally to protect against misunderstandings among the lay and professional public.

RESULTS

There were a total of 19 patients. Fourteen were referred directly and five were self-referred. There were 6 males and 13 females. Except for the previously noted single exception, their health was known. Sixty-eight interview hours were spent with the total group for an average of 3.6 visits per patient. The average number of patients per counselor visit was also 3.6.

Of the males the oldest was 34 and the youngest, 16. (Average age 26.2 years.) Of the females the oldest was 60 and the youngest, 12. (Average age 31.4 years.) Twelve were married, 5 were single, 1 was divorced and 1 was widowed.

On the basis of complaints reported the patients were categorized in the following manner:

1. *Anxiety—depression (9)*
2. *Obesity (3)*
3. *Parent—child (3)*
4. *Sexual frustrations (2)*
5. *Abdominal complaints (1)*
6. *Boy—girl problem (1)*

To ascertain if success, failure, or something in between was achieved each case was reviewed by the counselor in line with the goals established with the patient. Each case was judged by both the counselor and the physician. The following results were determined:

1. *Termination by mutual decision—14*
2. *Failed to continue—5*
3. *Goals attained—11*
4. *Goals not attained—7*
5. *Questionable—1*

It is interesting that in the *Goals not attained* group, 5 of the 19 failed to continue therapy. Four patients were seen only once and 3 of them were in the *Goals not attained* group.

THREE CASE SUMMARIES

1. A 33 year old, white female, married with two school age children. The patient was determined to be in good physical health. Her history of complaints to the physician included general apathy, periods of mild to moderate despondency, fatigue, and intermittent, unprovoked tearfulness.

Evaluation during three interviews revealed a perfectionistic, overly inhibited, rather anxious, self-effacing young woman whose central symptom, depression, was seen to be the manifestation of internalized anger and frustration with a rather shallow, hostile and rejecting marriage relationship.

With support, the woman was able to approach her husband about her concerns and as of this writing, both have agreed to seek marriage counseling.

2. A 26 year old, white male, married with no children, and self employed as a farmer. The patient complained of chronic tenseness, free floating anxiety with periods of panic, evidenced by crying, depression and fatigue, generalized confusion and immobility for periods lasting from a few hours to a day or more.

As of this writing, the patient has had three interviews and may be described as a highly controlled, dependent, somewhat rigid and fearful person who has habitually suppressed his anger. He was extremely compliant in his interpersonal relationships with tendencies toward perfectionism and low self esteem.

The patient demonstrated an ability to utilize supportive as well as insight therapy. The course of treatment was expected to be somewhat more lengthy than the average patient because of the problem of chronicity and well established patterns of behavior.

3. A 16 year old, white, male school drop-out referred by parents because of resistance to parental controls, poor peer associations, suspected drug use, unauthorized absences from the home for several days at a time.

The patient was seen as a rather unmotivated, hostile adolescent, with little goal direction. His manner was essentially indifferent, his behavior impulsive, and his judgment poor.

The patient and his parents were seen for a total of nine interviews with treatment emphasis placed on the parent-child relationship, considered the area of conflict most amenable to improvement. More indepth counseling was indicated for the patient but judged not appropriate at the time because of his low mo-

tivation and because of surface conflicts occupying the patient and his parents.

DISCUSSION

The authors believe this study has opened new channels of thought on how to better serve the patient in rural Iowa.

Our initial concern was whether a family counselor—an "outsider" so to speak—would be accepted by the community and more importantly by the individual patient in need. Secondly, we wondered if the patients would be offended by the family physician suggesting they seek such help in their own community —would it hurt the physician's practice? There has been no indication of community rejection of this service and among the patients served the majority felt it most worthwhile. To the second question, in only one instance was a patient offended by the suggestion that he seek counseling. This represented the loss of one patient to the physician.

A presumption is made that fear of going to a counselor is not associated with the place of treatment or with the counselor, but rather with the stigma attached to it. It is interesting that only 7 patients in the 7 years prior to this project actually went to a family counselor or psychiatrist at the suggestion of the family physician, without first being committed to a psychiatric hospital facility. In the past four to five years no fewer patients have been asked to seek this help than in the past year. The limited accessibility of the counselor was a deterrent to some additional patients.

The number of those additional patients who might have accepted this service at another more convenient time is not known. It is the opinion of the physician that a conservative estimate of 20-25 per cent would be appropriate.

As small as this project may seem, a little simple arithmetic brings home a significant point. In this practice the physician averages 4½ hours in the office per day six days a week. If he allocated 68 hours of office time for counseling, this would represent well over 2 working weeks in the office each year. Also the question of whether the physician could counsel as well as one specifically trained merits consideration. It was the opinion of the physician that he could not.

A further interesting facet of this study has been the development of mutual cooperation and respect between the counselor and the physician. This seemed to enhance the care of the patient as a total person. From the physician's perspective continuity of care was maintained, and from the counselor's point of view security was established in terms of not worrying about disturbing real or imagined somatic or visceral complaints.

CONCLUSION

It is difficult from a relatively small study to draw many firm conclusions. However, the authors were encouraged by the following:

1. Communities in rural areas will accept this service.

2. Patients will accept this service more readily if it exists in their community, in familiar surroundings, and (ideally) with the knowledge and involvement of their personal physician. The inhibitions (or reluctance) of the patients were seemingly reduced when they realized they were being seen at a place in their community or area where people generally go when they didn't feel well (for whatever reason), and not at a psychiatric facility. The simple fact that such a service was available and convenient played an important role, in our judgment.

3. The authors believe the level of competency and, therefore, the level of care was greatly enhanced by this team approach.

4. Continuity of care was maintained in virtually all cases, and this was rewarding to both the physician and the patient.

5. The fee of $15 per patient visit was considered reasonable in this area if judged by the collection, which was 100 per cent.

6. Suggesting to the patient that he seek counseling in his (or her) community did not detract from the physician's practice. The one patient who left the physician's care would have done so regardless of the circumstances.

7. It allowed the physician to devote many hours to the other medical needs of the area.

THE FUTURE

The authors are reasonably encouraged with the responses and findings, to the extent of considering a project expansion in the coming year. Expansion, to the authors' way of thinking, would mean a more comprehensive counseling service involving once-a-week interviews, a back up by other counselors, counseling of unwed parents and initial interviews for the child adoption process.

The counselor and physician would have to make this service known by contacting other physicians in the area, clubs, churches and the schools. Particular emphasis would be placed on contact with the schools' guidance counselors. To accomplish this, a formal association between the medical facility in a given community and a family and children's agency should be established.

In reviewing the literature, it is interesting to note Iowa has a suicide rate higher than the national average, 12.2 per 100,000 to 11.1 per 100,000. In one study 10 per cent of all patients seen in a rural setting needed psychiatric help while another 14 per cent would probably have benefitted from this type of service. On this basis it would appear a project similar to the one described here could go far in reaching these patients.

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FEW PHYSICIANS' ASSISTANTS SEEKING BOARD APPROVAL

Individuals seeking certification as physicians' assistants under the one-year-old Iowa program have been few in number, according to John K. MacGregor, M.D., chairman of the Governor's Advisory Committee on Physician's Assistants.

Only six applications of physicians' assistants to perform medical services under the supervision of a physician have been approved by the Board of Medical Examiners. Such authority was given to the Board in state legislation enacted in 1971.

"Many physicians, physicians' assistants and interested individuals may not be aware of the fact that the Board of Medical Examiners is administering the provisions of Section 148 (b) of the Iowa Code, which is an act to establish a program to permit physicians' assistants to work under a physician's supervision," said Dr. MacGregor, of Mason City. "We are anxious for those persons who may be interested in this field to be aware of the Board's involvement."

A provision in the new law requires the Board of Medical Examiners to approve programs for the education and training of physicians' assistants. One such program initiated last September by the University of Iowa College of Medicine has been approved by the Board.

Applicants for approval as physicians' assistants must show they have a preliminary education equivalent to at least four years of study in high school or other secondary school. They must be of good moral character and be a graduate of a program for the education and training of physicians' assistants approved by the American Medical Association, or present other evidence of equivalent education, experience and training for approval by the Board.

If an applicant is not graduated from an approved program, he or she will be referred by the Board to the University of Iowa for an evaluation of his or her educational preparation, previous experience and training, and he will be required to pass an equivalency examination with written, practical and oral phases.

The approval of an application for a physician's assistant to work under the supervision of a physician shall be granted on a year to year basis. When a nationally recognized certifying examination is approved by the Board, all physicians' assistants will be required to pass this test.

Inquiries regarding the physicians' assistants program in Iowa should be directed to Ronald V. Saf, Executive Director, Iowa State Board of Medical Examiners, 910 Insurance Exchange Building, Des Moines, Iowa 50309. (Telephone 515/281-5171)

Familial Horseshoe Kidney: A Case Report

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Iowa City

HORSESHOE KIDNEY, a common urologic anomaly, occurs in about 1:400 urologic admissions.[1] Patients may present with secondary renal disease during investigation for unrelated symptoms.[2] No evidence is available from the literature to suggest this urologic defect may be familial. Recently two sisters referred for hypertensive evaluation demonstrated this anomaly.

CASE HISTORIES

L. G., a 54-year-old white female, experienced dizziness, headaches, nausea and generalized weakness in August 1970. No past history of genitourinary disease or symptomatology troubled the patient.

She required hospitalization in 1967 for "a peculiar pressure in my head." At that time, family history revealed no hypertension, diabetes or renal disease.

Physical examination demonstrated an anxious white female in no distress. Blood pressure recordings ranged around 190/110. Cardiac enlargement, murmurs and intraabdominal bruits were absent.

Laboratory assessment revealed a blood urea nitrogen and creatinine of 22 and 1.0 mg per cent respectively. Urinary steroid excretion evaluation for functioning adrenal tumors remained in the average range. A glucose tolerance curve was consistent with adult onset diabetes. A urinalysis revealed no protein and only 2-3 white blood cells per high power field as formed elements. An excretory urogram (Figure 1) revealed equal nephrograms on the 20 and 40 second films. The 5 and 15 minute exposures delineated the medial deviation of lower pole calyces and axis rotation of the upper poles laterally, indicating the typical findings of a horseshoe kidney. Since no obvious renal vascular etiology for hypertension resulted from the evaluation, the patient received medical therapy. Upon discharge the blood pressure stabilized at 140/90 with Hydro-DIURIL, 50 mg daily.

L. L., a 58-year-old white female, developed urinary incontinence 19 years ago and sought medical consultation. Intravenous pyelograms

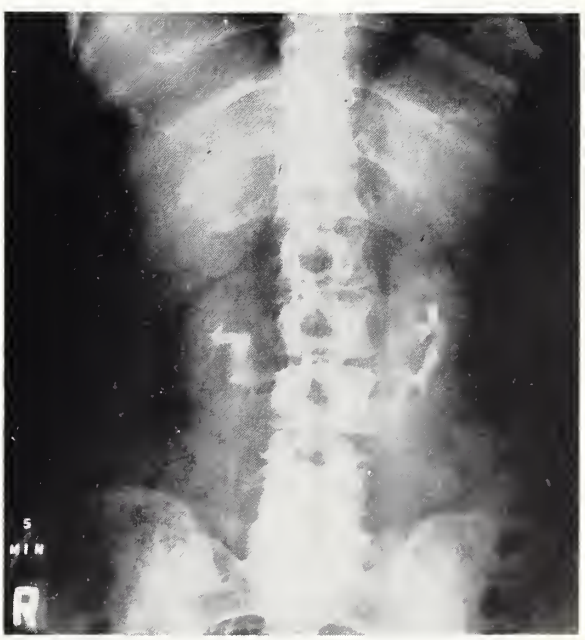


Figure 1. L. G. 70-56929 illustrates the five minute film of an excretory urogram in which the medial deviation of the lower pole calyces is evident. The lateral deviation of the upper pole with axis deviation of the kidney is well demonstrated.

Dr. Boatman was an instructor in the Department of Urology at The University of Iowa College of Medicine when this paper was prepared. He is now in private practice in Cedar Rapids, Iowa. Dr. Hawtrey is an associate professor in the Department of Urology.



Figure 2. L. L. 71-21749 represents a right oblique film of an intravenous pyelogram obtained after voiding at about 15 minutes. The caliectasis and medially deviated lower pole isthmus is well illustrated. Left segment of the horseshoe kidney is surgically absent.

demonstrated bilateral hydronephrosis in a horseshoe kidney which was treated by symphosiotomy. The more marked changes on the left required diversion by nephrostomy and a nephropexy. Renal function remained poor and a left nephrectomy removed this source of infection in 1952. In 1957 she developed hypertension and received medical therapy until her present admission. Recently her blood pressure escaped the usual medical control necessitating referral to University Hospitals in September 1971. No other historical information contributed to the present illness.

On physical examination the patient's blood pressure was recorded as 165/100 with no change in the optic fundus. The right kidney was palpable as a non-tender mass in the right lower quadrant lateral to the umbilicus.

Urinalysis revealed no protein but 2-4 RBC's and WBC's per high power field. Blood sugars were consistently elevated on A.M. and P.M. specimens; 180 and 165 mg per cent, respectively. Endocrine evaluations for secreting adrenal or thyroid tumors were unrevealing. Intravenous pyelograms revealed an enlarged right kidney with dilated calyces and transport of contrast media through the ureteropelvic junction into a uniform small caliber ureter (Figure 2). The findings were consistent with the previously described preoperative findings. The left kidney did not visualize since it was surgically absent.

DISCUSSION

These women share three interesting medical problems: horseshoe kidney, abnormal glucose tolerance curves with borderline diabetes mellitus and hypertension. The genetic relationships in diabetes and hypertension are well known. No evidence from the medical literature suggests a familial incidence of horseshoe kidney. A chance occurrence of the anomaly cannot be excluded, but seems unlikely in view of the other genetically related defects. It is interesting that both have the same renal anomaly, yet the resultant changes in renal function and pyelographic appearance are so different. We were unable to ascertain in the family background a history of renal disease or presence of this anomaly in other siblings or parents. There was a difference of four years in age with one sister (L. L.) having marked hydronephrosis with secondary infection and destruction of renal tissue, necessitating surgical intervention (heminephrectomy). At present, her renal state seems stable in that intravenous pyelograms remained unchanged since surgery 19 years ago. Conversely, the other sister (L. G.) has had no history to suggest renal disease or infection. Her excretory urograms were essentially normal with typical radiographic appearance of horseshoe kidney with unobstructed upper collecting systems. It is most likely that she will not have further urological difficulties from this anomaly, since the majority of cases with these pyelographic features remain asymptomatic. The great majority of congenital upper urinary tract anomalies make themselves evident and first produce symptoms between the ages of puberty and 35.[3]

There are many reports in the literature which discuss the relationship of renal disease

and hypertension. Dees felt that hypertension was caused by this renal anomaly in three cases of his series.[3] In 105 cases of horseshoe kidney reviewed at the University Hospitals from 1939 to 1970, 27 patients were considered to be hypertensive.[4] Further diagnostic studies such as arteriography, renal vein catheterizations for renin determinations and split renal function tests have been obtained in selected cases. The results of these studies have been unrevealing. Certainly this is a higher incidence of hypertension than would normally occur in a random sample of the population, but it should be kept in mind that many renal anomalies were discovered during pyelograms ordered by our internal medicine colleagues as part of the hypertensive evaluation.

SUMMARY

The family unit described in this report suggests that the tendency to horseshoe kidney may be inherited. Family members with a history of horseshoe kidney might be profitably screened by intravenous pyelography if symptoms warrant this examination.

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Morbidity Report for June, 1973

Disease	June 1973	1973 to Date	1972 to Date	Most June Cases Reported From These Counties
Adenovirus infection	3	4		Keokuk, Polk
Amebiasis	5	12		Dallas, Johnson, Muscatine
Brucellosis	1	3	22	Dubuque
Chickenpox	471	10726	6397	Scattered
Conjunctivitis	42	798	638	Scattered
Cylomegalovirus infection	1	3		Bremer
Eaton's agent infection	1	11		Boone
Endolimax nana infection	1	1		Johnson
Enteropathogenic E. coli infection	3	4		Dubuque, Polk
Enterovirus infection	1	1		Woodbury
Gastrointestinal viral infection	102	5236	4216	Scattered
Giardiasis	1	7		Pottawattamie
Hepatitis, infectious	17	132	160	Scattered
Hepatitis, serum	1	22	38	Polk
Herpes simplex	8	36		Dallas, Johnson, Union
Herpes zoster	1	7		Scott
Histoplasmosis	3	3	18	Appanoose, Johnson, Polk
Impetigo	5	203	220	Scattered
Infectious mononucleosis	27	453	561	Scattered
Influenza-like illness	122	11368		Scattered
Meningococcal meningitis	5	16		Scattered
Meningitis, bacterial	1	2		Des Moines
Meningitis, type unspecified	1	12	11	Black Hawk
Meningo-encephalitis	1	6	3	Scott
Mumps	189	2973	5635	Scattered
Pediculosis	7	96		Jasper, Scattered
Pinworms	3	5		Johnson, Keokuk, Scott
Pneumonia	72	664	491	Scattered
Rabies in animals	25	135	195	Scattered
Ringworm, body	1	68		Benton
Rocky Mountain spotted fever	4	4		Johnson, Linn, Mills
Rubella	18	194	377	Scattered
Rubeola	36	273	703	Scattered
Salmonellosis	27	264	66	Scattered
Scabies	2	8		Allamakee
Shigellosis	33	75	151	Scattered
Streptococcal infections	306	4350	4327	Scattered
Tuberculosis, active	22	65	48	Scattered
Tuberculosis, inactive	1	13		Tama
Venereal disease gonorrhea	586	2932	3122	Scattered
syphilis	48	198	241	Scattered
Viral myocarditis	1	1		Muscatine
Erythema infectiosum	42	1337		Scattered

Editorials

M. E. ALBERTS, M.D., Scientific Editor

CHILLING THOUGHTS

How does frostbite and hypothermia appeal to you on this hot summer day? In Iowa we have extremes in weather, from hot, humid 90°-100°F summer days to blustery −20°F winter weather. ALASKA MEDICINE,* March 1973, is devoted to a series of discussions on the current concepts of frostbite and hypothermia. The data presented is based largely on military studies in the arctic environs of Alaska. The articles are written well and illustrated with excellent color photographs, as well as concise case histories.

Comparisons are made of various ways of thawing frostbitten extremities—excessive heat, spontaneous thawing, rapid thawing, and delayed thawing with ice water. The medical evaluations conclude the therapeutic regimen should consist of rapid thawing where possible (at a temperature of 100°-112°F), avoidance of infection (sterile precautions as with burned patients), whirlpool baths at 90°-98°F, continued active exercise, and delayed surgical intervention until there is complete demarcation with spontaneous amputation of soft tissues.

Hypothermia, or general body cooling, presents further problems. Resuscitative techniques require cardiac and respiratory support (possible tracheostomy and/or cardiac defibrillation should be anticipated), intravenous fluids, prevention of infection, and general body "core" rewarming. The latter is done with peritoneal dialysis at 110°F using 2 liters of dialysate in the exchange over a period of 20-30 minutes. Warmed peritoneal dialysis entails "core" rewarming to have its effects centrally upon the heart and blood, thus maintaining the protective peripheral vasoconstriction. The dialysis also assists in restoring the biochemical balance as well as restoring the heart to a normal sinus rhythm.

These papers are recommended to any physician who might be called upon to treat a victim of the cold environment. The experiences of the patients described in the case histories provide "chilling" reading; the difficulties facing peoples who live in arctic areas are difficult to appreciate. Here in the Midwest we are concerned with the toll of automobile accidents and polluted air. The arctic equivalent is being stranded in the deep snow with chill temperature at −85°F.—M.E.A.

* ALASKA MEDICINE, Official Journal of Alaska State Medical Association and Alaska Dental Society, **15**:26-59, March, 1973.

A NEW LANGUAGE

Recent advances in neonatology have produced a new battery of strange abbreviations. On the surface it appears not unlike governmental "gobbledygook," but there is precise meaning in each instance. Writings and discussions on the care of tiny infants contain references to RDS, IPPB, CPAP, CPAB and BPD. Thus we may read that a tiny infant suffering from RDS because of being a SGA, was treated in the NICU first with IPPB but because this was

ineffective CPAP was instituted with the hope to reduce BPD.

A recent article in MINNESOTA MEDICINE* presents a good and timely review of the methods of respiratory assistance for the newborn. Dr. Burke-Strickland considers the various methods and indications for the treatment of respiratory distress syndrome (RDS) in the small for gestational age newborn (SGA). The intermittent use of bag assistance with a hand resuscitator may be all that is necessary for the mildly afflicted infant requiring special care in the neonatal intensive care units (NICU). However, if the baby is immediately dusky or apneic as soon as bagging is stopped, or if more than 40% ambient oxygen is required to relieve cyanosis, continuous positive airway pressure (CPAP) should be instituted. With CPAP assistance the infant still uses his own respiratory drive and does his own breathing, but the work of breathing is reduced. Lung expansion improves, ventilation is enhanced, oxygenation improves, all of which reduces the risk of bronchial pulmonary dysplasia (BPD). In some instances the CPAP must be combined with a respirator to provide continuous positive pressure breathing (CPAB) wherein the respirator assumes the entire work load of breathing. When the respiration failure is due to extrapulmonary causes, such as with drug depression, intermittent positive pressure breathing (IPPB) may suffice to assist the function of a normal lung.

There are possible complications with ventilatory assistance. Pneumomediastinum and pneumothorax are calculated risks, massive air embolism has been reported. Pulmonary edema and heart failure may occur because of an intrathoracic pressure rise causing a decrease in cardiac output. Infection, of course, is another possible complication. Nevertheless, with the newer methods of respiratory assistance, there is a definite increase in the salvage rate of these tiny distressed infants. Learn the language, know the procedures and indications. At least know where such services are available. At the present time neonatal intensive care units are in operation in Des Moines, Iowa City, Dubuque and Waterloo.—M.E.A.

* Burke-Strickland, Martha: Respiratory assistance in newborn, MINN. MED. 56:419-423, 1973.

I REMEMBER WHEN . . . DO YOU?

This brief feature appears from time to time in the JOURNAL and is a project of the Society's Historical Committee. One of the able members of this committee, and an Iowa medical historian of significant stature, died this spring. George E. Morrissey, M.D., Davenport, contributed much to the medical profession and to its archives. A meaningful tribute to Dr. Morrissey by Mrs. Richard A. Moore of Davenport appeared in that community's newspaper:

"The citizens of Davenport have suffered a great loss. The death of Dr. George E. Morrissey came as a cruel shock to his colleagues and as an almost almost overwhelming sense of desolation to his patients.

"He was a selfless, wise and gentle man. Each of his many patients can recount some personal experience which revealed his commitment to them. He dealt compassionately with their fears and problems when his own heart was heavy, he listened sympathetically to their pains and pangs when his own body ached and his days stretched endlessly from hospital to office to nursing home to house calls when he himself was bone tired. In short, he was the completely dedicated doctor.

"How fitting that his initials should so eloquently describe him. For in fact, Dr. George E. Morrissey was a gem. A shining jewel of a man whose luster will not be dimmed by death, but will glow warmly in the memories of all who knew him."

The Historical Committee agrees wholeheartedly.—OTTO N. GLESNE, M.D., *Chairman, IMS Historical Committee.*

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

'BUILT-IN ORDERLY ORGANIZED KNOWLEDGE SYSTEM'

I hope you may be as charmed and amused as I was with the following description of a marvelous learning aid (original author unknown):

"A new aid to rapid learning has made its appearance. This device is known as 'Built-in Orderly Organized Knowledge System.' It has many advantages over the old-style learning and teaching aids. There are no wires, it needs no electricity, it is made entirely without any mechanical parts to go wrong or to need replacement.

"Basically this device consists only of a number of paper sheets. These may run to several hundred if there is a lengthy program of information to be covered. Each sheet bears a number in sequence and is held in the proper order by a special locking device called a binding.

"Each sheet of paper presents the user with an information sequence in the form of symbols which he absorbs optically for automatic registration on the brain. When one sheet has been assimilated a flick of the finger turns it over and further information is found on the other side.

"By using both sides of each sheet in this way great economy is effected, thus reducing both size and cost. No buttons need to be pressed to move from one sheet to another, or to start it working. The user may turn at will to any sheet, going backward or forward as he pleases. A location finder is provided near the front for any required information sequence.

"A series of these devices may be stored on handy shelves, and for ease of reference the exact program schedule is generally indicated on the back of the binding. Once purchased there is no further upkeep cost for the motive power is supplied by the brain of the user. There is, however, a small accessory available at trifling extra cost known as a 'bookmark.' This enables the user to pick up his program where he left off at a previous learning session.

"The maker is allowed to copyright and sell this system under its generic name which is actually an acronym for 'Built-in Orderly Organized Knowledge.' Altogether it seems to have great advantages and no drawbacks. We predict a big future for BOOKS."

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

OKOBOJI OUTING . . . Third annual Okoboji Dialogue will be Friday, September 14, under direction of The University of Iowa Office of Continuing Medical Education. Informal discussion between physicians and hospital administrators on medicine and hospital operation is planned. IMS is a co-sponsor. For further information, contact R. M. Caplan, M.D., at The U. of I. Office of Continuing Medical Education.

IOWA MEDICAL MISCELLANY

(Continued from page 381)

AMA ANNUAL SESSION . . . Four-page IMS NEWS BULLETIN sent July 5 summarized key policy decisions made by AMA House of Delegates during recent sessions in New York. Action on professional standards review organizations stressed importance of peer review of physicians' services being done by organizations composed of practicing physicians.

INFANT MORTALITY . . . U. S. infant mortality rate continues to decline. For first six months of 1972, the rate was 18.6 per 1,000 live births, according to National Center for Health Statistics. The infant mortality rate was 19.5 for the same period in 1971. In 1940 it was 47.0.

FAMILY PRACTICE RESIDENTS . . . 1,015 medical graduates are now in family practice residency programs, reports American Academy of Family Practice. Figure doubles number of a year ago. Three years back there were 20 approved residency programs; now there are 107. There are 63 departments and divisions of family practice in nation's 105 medical schools.

REGIONAL MEETINGS . . . IMS will cooperate with the U. of I. College of Medicine and the State Office for Comprehensive Health Planning in presenting a series of regional meetings beginning in the fall. Medical and health resources in the regions will be assessed with a consideration of ways to meet real and anticipated needs.

PRACTICE WORKSHOP . . . Planning for a Fall Practice Management Workshop for interns and residents has been authorized by the IMS Board. Tentatively scheduled for IMS Headquarters, the workshop will be supported by the American Medical Association.

WEBSTER COUNTY . . . Annual Medical Day of the Webster County Medical Society will be Saturday, September 8. Program at the Starlite Restaurant in Fort Dodge will begin at 9:45 a.m. and will include six outstanding speakers from midwestern medical centers. The specific program has been mailed to 400 physicians in northwest Iowa. Contact M. E. Kraushaar, M.D., Fort Dodge, for more details.

EAR PIERCING . . . Statement regarding ear piercing recommended by IMS Committee on Delegation of Authority has been approved. It urges procedure not be done in a non-medical or commercial setting.

PAGE COUNTY MEETS . . . Fall meeting of the Page County Medical Society September 19 in Shenandoah will feature talks by Drs. J. A. Spittell, Jr., and Albert D. Newcomer of the Mayo Clinic, and Drs. George Bedell and C. A. DeProsse from The U. of I.

ANTIBIOTICS MEETING . . . Fourth annual meeting on antibiotics and infection will be October 11-13 at The U. of I. Six out-of-state physicians will be among the conference faculty. Further information is available from Ian Smith, M.D., Department of Internal Medicine, University Hospitals, Iowa City, Iowa 52242.

OBSERVE 100TH ANNIVERSARY WITH SPECIAL SEMINAR

The Des Moines-Louisa County Medical Society will commemorate its 100th anniversary by holding a half-day scientific seminar Wednesday, October 3, at the Burlington Country Club.

Seminar speakers include the following:

Clarence W. Lillehei, M.D., Professor of Surgery and Department Chairman, Cornell University Medical Center—*Recent Advances in Cardiovascular Surgery.*

William Ruth, M.D., Professor of Medicine and Chief, Section of Pulmonary Disease, University of Kansas Medical Center—*Chronic Obstructive Lung Disease, Current Concepts.*

Stuart Levin, M.D., Associate Professor of Medicine and Chief, Section on Infectious Diseases, Rush Medical College and Rush Presbyterian St. Luke's Medical Center—*The Rational Use of Antibiotics in Day to Day Medical Practice.*

William E. Connor, M.D., Professor of Medicine and Director, Clinical Research Center, University of Iowa Hospitals.—*Lipids, Their Metabolism, and Their Clinical Implications.*

The seminar will begin at 1 p.m. Persons interested in attending may contact Robert L. Todd, M.D., North Hill Medical Center, or S. F. Guiang, M.D., 620 North 8th Street, Burlington, Iowa.

About IOWA Physicians

Dr. Julian Bruner, Des Moines, has been elected to membership in the Royal College of Surgeons. He will travel to London this fall to be formally admitted. . . . **Dr. Denis D. Faber, Jr.,** Dubuque, has been appointed a director of the Key City Bank and Trust Co. Dr. Faber has practiced in Dubuque for five years and is chief of staff of Finley Hospital. . . . **Dr. Hormoz Rassekh,** Council Bluffs, is new president of the Iowa Psychiatric Society; and **Dr. John Gambill,** Clarinda, is secretary-treasurer. Dr. Rassekh is member of IMS Executive Council. Dr. Gambill is superintendent of the Mental Health Institute in Clarinda.

Dr. Thomas J. Carroll, Sibley, recently received his bachelor's degree at Iowa State University. Dr. Carroll earned the M.D. degree at U. of I. College of Medicine 25 years ago. . . . **Dr. D. A. Rater,** Cedar Rapids, has been certified by the American Board of Cardiovascular Diseases. A 1964 U. of I. medical graduate, Dr. Rater served an internal medicine residency and a cardiology fellowship at University of Kansas School of Medicine. . . . **Dr. Saman Choontanom** has joined **Drs. Opas** and **Puantong Jutabha** in medical practice in Sigourney. Dr. Choontanom is a 1964 graduate of the Chiengmai Medical School, Thailand, and interned there one year. In 1965 he located at Wayne County General Hospital, Eloise, Michigan, where he served an internship and a residency in surgery. He was chief resident in surgery for one year. In 1970 Dr. Choontanom returned to Thailand to practice for two years; this past year he has been in private practice in Virginia.

Dr. Herman Hein has joined the Muscatine Community Health Center. Dr. Hein received M.D. degree from U. of I. College of Medicine in 1963, and returned there in 1965 to complete a pediatrics residency. In the interval he served an internship and a one-year residency in pediatrics at Children's Medical Center of Parkland Hospital in Dallas, Texas. Dr. Hein is a Fellow in the American Academy of Pediatrics and served as a consultant to the Headstart Program. He was previously director of Northeast Iowa Regional Perinatal Program. . . . The new coronary care unit at DeWitt Community Hospital has been dedicated to the late **Dr. Leander Schaefer,** Clinton, for his many years of service. A memorial plaque so designates the unit. . . . **Dr. William A. Fisher** has left the Creston Medical Clinic to join a pediatrics clinic in Harlingen, Texas. Dr. Fisher came to the Creston Clinic in 1953.

Dr. William C. Rosenfeld, Mason City, has been named a Diplomate of American Board of Internal Medicine and accepted as member in American College of Physicians. A 1961 graduate of U. of I. College of Medicine, Dr. Rosenfeld had an internal medicine residency and a subsequent fellowship in cardiology at University Hospitals in Iowa City. . . . **Dr. Otto E. Senft,** Monticello, addressed Iowa Hypnosis Society at a recent meeting at University of Iowa. Dr. Senft's subject: "Uses of Hypnosis in General Medical Practice." . . . **Dr. Gemo Wong,** former Mt. Carmel, Illinois, physician and surgeon, recently began practice of medicine in Monticello. Dr. Wong received M.D. degree in the Philippines and served a five-year residency at Mt. Mercy Hospital in Chicago, Illinois, before locating in Mt. Carmel.

Dr. Paul Brecher, Storm Lake, announced his retirement from active medical practice in May. A 1938 graduate of U. of I. College of Medicine, Dr. Brecher served his internship at

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$20,000 to $24,000	4.08%	5.00%	7.35%
$24,000 to $28,000	3.84%	5.00%	7.81%
$28,000 to $32,000	3.66%	5.00%	8.20%
$32,000 to $36,000	3.48%	5.00%	8.62%
$36,000 to $40,000	3.30%	5.00%	9.09%
$40,000 to $44,000	3.12%	5.00%	9.62%
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Nashville General Hospital in Tennessee, and began his practice in Storm Lake in 1939. . . . The medical staff of Baum-Harmon Hospital in Primghar, recently presented an honorary membership to **Dr. N. E. Weems,** Paullina, in appreciation of his 50 years of service. Dr. Weems is a life member of Iowa Medical Society. . . . **Dr. W. E. Owen,** St. Ansgar general practitioner, recently added the services of a physician's assistant, Mrs. Dorothy Hastings, P.A. Prior to her advanced training as physician's assistant at Mayo Clinic, Mrs. Hastings worked as a general, surgical, medical and obstetric nurse at Mercy Hospital in Mason City and Mitchell County Memorial Hospital in Osage. She worked eight years as a public health nurse in Winneshiek County. . . . The Linn County Board of Supervisors recently named **Dr. R. Paul Penningroth,** Iowa City, medical director of county mental health services. The new post was created after Linn County assumed responsibility for the former county mental health center.

Dr. Charles F. Eddingfield, a general surgeon in Carthage, Illinois, has joined Tri-State Medical Group in Keokuk. Dr. Eddingfield received a medical degree from University of Illinois in 1962. He served an internship at St. Francis Hospital in Peoria, Illinois, and a general surgical residency at Creighton University in Omaha, Nebraska. . . . **Dr. George N. Bedell,** professor of internal medicine at U. of I. College of Medicine, recently received the Walter Bierring Award from the Iowa Tuberculosis and Respiratory Disease Association. The award is presented annually to an outstanding Iowa physician, in memory of Dr. Walter Bierring who pioneered in chest medicine. Dr. Bedell is chief of the pulmonary disease section at University Hospitals. . . . **Dr. James E. Kelsey,** Des Moines, has been named medical director for Northwestern Bell Telephone Company, and has moved to Omaha, Nebraska. Dr. Kelsey has been in private practice in Des Moines since 1956. . . . **Dr. Robert Chapman,** Cedar Rapids, participated in ground-breaking ceremony for $13.9 million addition to University Hospitals in Iowa City. Dr. Chapman is vice president of Iowa Medical Society.

The following Iowa physicians were program participants at recent Emergency Cardiac Care Symposium in Des Moines—**Dr. D. G. Boek,** Fort Dodge; **Dr. Dean E. Finken,** Logan; **Dr. James W. Rathe,** Waverly; and **Dr. F. O. W. Voigt,** Oskaloosa. The annual symposium was sponsored by the Iowa Heart Association. . . . Three Des Moines physicians—**Dr Arthur H. Downing,** ophthalmologist; **Dr. Thomas D. Ghrist,** internist; and **Dr. John H. Kelley,** orthopedic surgeon, presented a recent Des Moines Rotary Club luncheon program. "Medical and Surgical Gadgetry," was their topic; they demonstrated small inventions that make a big difference to sick and injured Iowans. . . . **Dr. C. N. Hull,** Des Moines, is new president of Iowa Society of Anesthesiologists. He was elected at recent annual meeting in Des Moines.

Dr. William D. deGravelles, Jr., chief of physical medicine and rehabilitation at Younker Memorial Rehabilitation Center of Iowa Methodist Hospital in Des Moines, has been elected to board of directors of the International Association of Rehabilitation Facilities. . . . **Dr. Charles Bendixen,** Marshalltown, described his trip to Alaska in a single-engine plane at recent meeting of Marshalltown Rotarians. The trip was arranged by the Flying Physicians Organization. Dr. Bendixen was accompanied by his wife. Thirty-four planes and 119 people made the journey 120 miles above the Arctic Circle. Dr. Bendixen had no flying problems but was chased out of an area by fog at one point. Icing was also a problem during a holding pattern over one airport. . . . **Dr. R. L. Bartley,** Audubon, discontinued his practice June 20 to become associated with the Taylor Student Health Center at Southwest Missouri State University in Springfield, Missouri. Dr. Bartley practiced medicine in Audubon for 19 years with **Dr. H. K. Merselis.**

Dr. Opas Anothayanontha has located in Traer and re-opened the office of the late **Dr. G. M. Dalbey.** Dr. Anothayanontha is a graduate of University of Medical Science in Thailand and interned at Mercy Hospital in Des Moines. Traer residents recently welcomed their new physician at a special reception. . . . **Dr. Frederick C. Brush,** Mason City urologist, recently began two months of service aboard the hospital ship, S. S. Hope, in northeast Brazil. . . .

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PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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THE QUESTION BOX

(Continued from page 384)

Iowa is very difficult to control. Unless this is changed our efforts to increase the number of physicians will have little effect on improving health care.

For the past two decades Iowa physicians have been moving away from smaller communities, even away from our larger towns. Many of the reasons that caused these physicians to move are involved with the method or type of practice that is conducted in smaller communities. Only physicians can correct these problems. In the long run it may be that the distribution of physicians may be the most difficult of these problems.

Does Iowa have problems of any greater magnitude than other comparable states?

Iowa's medical manpower problems are very similar in type and magnitude to the problems present in comparable states, and the problems of providing medical care in rural areas are similar in all of rural America.

However, the possibility of solving these problems is more likely in Iowa than in most states. Our rural community has a strong economy, the towns are vigorous and the quality of life is good. The major problem seems to be that of redesigning medical practice in rural areas so that it will be attractive to young physicians—and we should have the concern and the imagination and the resources to do that.

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Medical Assistants

by TENORA MEYER, CMA

1973 CONVENTION REPORT

Why do we have conventions and why do we attend? Answers vary. Job enrichment and fellowship are two answers high on my list. All Iowa chapters were well represented at the State Convention in Des Moines May 4, 5 and 6. The enthusiasm was apparent.

Elected to office were JoAnn James, Mason City, President-Elect; Nancy Winter, Davenport, Vice President; Frances Hansen, Sioux City, Secretary, and Jean Gold, Davenport, Treasurer. Installed as president was Sally Gesink of Sioux City. Installing officer was Colleen Proffitt of Des Moines.

Saturday's program included an "Alcoholism" panel with The Reverend Kermit Marsh, Dr. Erle Fitz and Gene Messenger. Shirley Muelenthaler moderated. New approaches to the treatment of alcoholism were explained.

Saturday's "Top of the Tower" luncheon featured a style show by Feldman's Phase II, Des Moines.

Catherine Condon, M.D., Des Moines, presented a kidney dialysis program Saturday afternoon. She described kidney disease and reported on cases successfully treated with dialysis. She also discussed kidney transplants.

On the lighter side, comedian Henny Youngman entertained at the Saturday banquet. Dr. Albert Clemens was master of ceremonies.

A Sunday highlight was Dr. John Kelley's presentation on "Legislation and the Doctor." He explained the procedure of lobbying and cited the results obtained by different groups during the legislative sessions.

Elvera Fisher, R.N., C.M.A., Chicago, AAMA representative, also addressed the group on Sunday. She spoke of the progress in the medical assistant field, the educational programs available, which now will include a complete home study course with certification as the goal.

Betty Ehlert, as convention Chairman, and Colleen Proffitt, her able assistant, as well as the other members of the Des Moines Chapter, did an excellent job with the 1973 convention. The 1974 convention will be in Sioux City.

SEPTEMBER EDUCATIONAL SEMINAR
Sept. 29-30, 1973—Holiday Inn, Ames, Iowa
Make your motel reservations directly with Holiday Inn

RATES: Singles $11.50
Twins: 2 persons $16.50
Twins: 3 persons $19.50
Twins: 4 persons $22.50

Note: If you have a Holiday Inn in your city, they can help you with the reservation. A complete educational program will be printed in a future issue.

PATHWAY TO MONUMENTAL GOALS

The 17th annual AAMA convention will be October 23-27, 1973 at the Shoreham Hotel, Washington, D. C. The convention theme as listed above provokes great expectations. Many pre-convention and post-convention tours have been planned to the Nation's Capitol, Arlington Cemetery, Alexandria, Mount Vernon, the Kennedy Center, Annapolis, Malaga, Spain and Rome, Italy. Advance packet registration is $60, if made by September 15, 1973. A complete program will be printed in a future issue. For specific information you may contact American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago, Illinois 60601.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

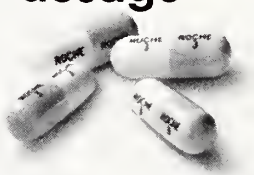
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various psychoneurotic states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported at recommended doses, use caution in administering to addiction-prone individuals or those who have been known to increase dosage; withdrawal symptoms (including convulsions), following discontinuance of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

President's Page



How the Society's legislative assembly will be structured in the coming years is a crucial topic scheduled for debate next month (October 12-14) when the House of Delegates holds its second 1973 session. This significant and controversial matter was discussed at length by the House in April. At that time the Standing Committee on Articles of Incorporation and By-Laws was instructed to prepare new governing language on delegate selection.

In acting on the recommendations of a special committee the House deferred for local consideration and October vote (1) retention of 12 councilor districts with a realignment to achieve numerical equalization (this can be accomplished by a simple action of the House), and (2) a revamped manner of selecting delegates to the House on a district basis with one delegate for each 15 members (or major fraction thereof) within a district; provisions exist here to foster representation from small counties.

On page 424 you will find this matter discussed further. Also, in the July JOURNAL, in the proceedings of the House of Delegates, you will find (1) the action recommended by the Reference Committee and approved by the House, and (2) the report of the special committee on which the action is based.

May I end with this plea: Please discuss this important proposal with your local colleagues, formally or informally, and give your delegate(s) the benefit of your thinking so he(they) can represent you effectively in October.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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IOWA Medical Miscellany

FOR RESIDENTS . . . A two-day practice management workshop will be offered October 30-31 at IMS Headquarters for senior medical residents who expect to enter private practice soon. 25 participants will be selected on a first-come, first-serve basis. All residents now training in Iowa will receive notification of the program which is sponsored jointly by the Society and AMA.

PSRO MEETING . . . Views on PSRO geographic designation were presented August 20 by the IMS and Iowa Foundation for Medical Care, among others, at a meeting held under the auspices of the Kansas City HEW Regional Office. The session—one of four in this HEW region—was described as information gathering in nature. It occurred at IMS headquarters. HEW must designate the PSRO areas by January 1, 1974.

MERGED . . . Merger occurred this summer of the Bethesda General and Mercy Hospitals in Fort Dodge. The two have incorporated as Trinity Regional Hospital of Fort Dodge.

IFMC . . . Annual meeting of the Iowa Foundation for Medical Care occurred July 26. New board members are A. J. Havlik, M.D., R. M. Chapman, M.D., and V. G. Kirkegaard, M.D. Modifications in the Foundation by-laws, approved by the board, have been put to a mail vote of all Foundation members The modifying language, if approved, will qualify the Foundation for designation as a Professional Standards Review Organization. Changes eliminate the initial dues requirement and open Foundation to all licensed physicians.

MORE ON FOUNDATION . . . On independent, trial basis, Iowa Foundation, in cooperation with Blue Cross/Blue Shield, will perform PSRO functions in the private sector over next few months. Cooperative effort with hospital medical staffs is intended as a gearing up exercise for what is anticipated under PSRO.

BLUE SHIELD . . . (1) Insurance Commissioner has recently approved sale of Blue Shield UCR contract to individuals, marketing on this basis will begin in near future; (2) New in-house computer claims processing system for regular BS business will replace former "quill pen" approach and eventually reduce "turn-around" time to week-and-a-half; (3) Larry W. Goetz, M.D., Creston, is only physician (he replaces W. A. Fisher, M.D., who's moved to Texas) newly elected to BS board of directors, others were re-elected.

SCANLON FOUNDATION . . . Grant of $5,000 has been received from the Interstate Postgraduate Medical Association of North America for use in the medical student loan program. The donors have requested that priority be given to loan applicants expressing interest in family practice. IPMANA trustees from Iowa are D. C. Conzett, M.D., Dubuque, R. N. Larimer, M.D., Sioux City, and S. P. Leinbach, M.D., Belmond.

AT WORK . . . Interim committee to study IMS finances, appointed in April by the House of Delegates, is evaluating fiscal status of the Society preparatory to reporting to the House in October. D. O. Newland, M.D., Des Moines, is chairman of the committee.

STUDENT MEDICAL SOCIETY . . . Paper work necessary to formalize student medical society authorized by the IMS House of Delegates is continuing; a constitution is in draft stage with IMS legal counsel advising.

(Please turn to page 442)

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 63 No. 9
SEPTEMBER 1973

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Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	TMP/SMX (1:20) SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Important note: **Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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House of Delegates Reapportionment

On October 12, 13, and 14, 1973, the Iowa Medical Society House of Delegates, in fulfillment of an assignment made in April, will meet in Des Moines to consider as one item of business the important subject of reapportionment. In its April action, the House urged that use be made of the intervening time (from April to October) for local discussion (by county societies) of the mechanics and implications of the reapportionment proposal. This activity is encouraged so the delegates voting on the measure next month will have an opportunity to gather grass roots reaction and receive instructions as desired. The *Journal* offers this resumé of the April House action as a possible springboard or stimulus for local discussion. The July issue of the *Journal* carries the official proceedings of the House of Delegates and will provide a more complete record of the deliberations.

In its April report to the House of Delegates, the Reference Committee on Articles of Incorporation and By-Laws praised the efforts of the special Ad Hoc Committee on House of Delegates Apportionment. Assuring a broad and effective representation of the medical profession in the IMS House of Delegates was cited as the objective which the Ad Hoc Committee sought in developing its recommendations.

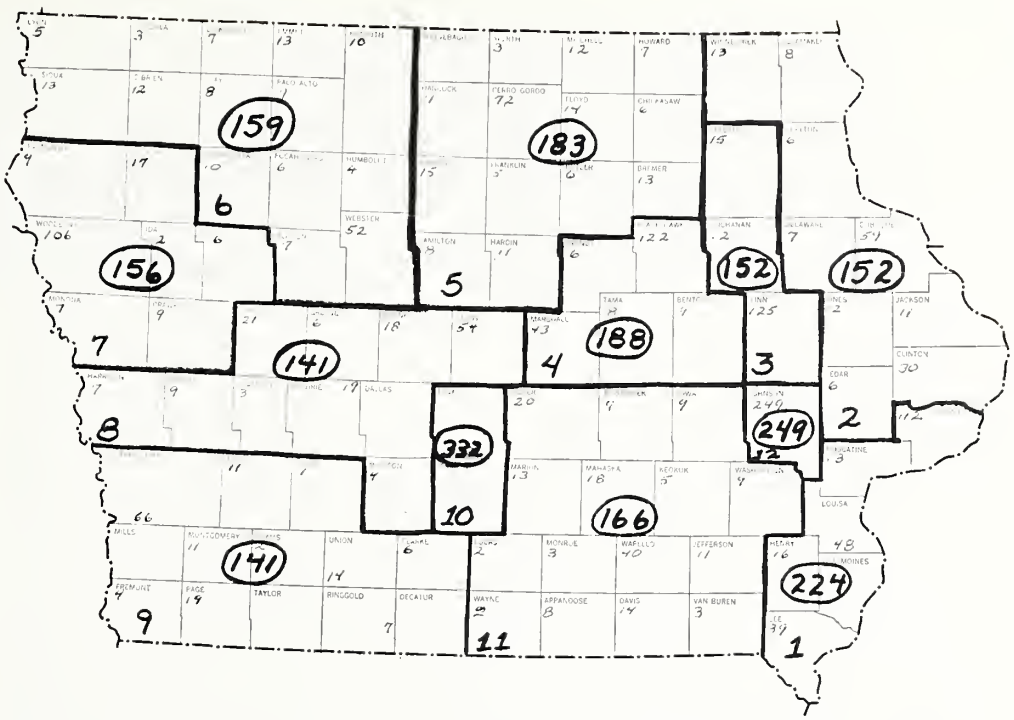
In its preamble the Reference Committee opined that (1) Society performance will be in direct relation to local initiative and local leadership (regardless of whether *local* is interpreted as a county, multi-county or district entity, and (2) an "updating of the organization of the House of Delegates may be the catalyst necessary to stimulate the medical profession in Iowa to pursue with new vigor those important scientific and socio-economic matters that will deserve our maximum attention in the years just ahead."

The House approved the two inter-related Resolveds which follow. The first of these has guided the Standing Committee on Articles of Incorporation and By-Laws in its development of formal amending language to be presented and considered in October:

- Resolved, That the following language from the report of the Ad Hoc Committee (with the italicized words added for clarity and emphasis by the Reference Committee) be referred to the Standing Committee on Articles of Incorporation and By-Laws, and that it be instructed to prepare the necessary implementing language for presentation at a Regular Meeting of the House of Delegates in the Fall:

"1) The present number of councilor districts (12) should be retained. However, in order to achieve a more equal proportion of members in each district, the present councilor districts should be realigned. This could be accomplished without an amendment to the Articles and By-Laws and could be achieved by a simple action of the House of Delegates. The suggested realignment of districts is illustrated in the accompanying map. It is recognized that a county medical society for various reasons may want to be in a different district than the one recommended. Final geographic boundaries would be up to the House of Delegates but the Committee believes it essential

Any resolutions on House reapportionment which evolve from county society discussion and action may be submitted for consideration by the House when it evaluates this important matter next month.



Circled figure is total number of Iowa Medical Society members in each district. Small number in each county represents the number of physicians in that particular county. This district realignment proposal has been submitted by the Ad Hoc Committee on House of Delegates Apportionment.

that all districts be compact (contiguous) and not unduly disproportionate in doctor population.

"2) Each *councilor* district would be allowed to elect one delegate for each 15 members or *major* fraction thereof in the district. In order to assure that the smaller counties have the opportunity to be represented in the House, it is further recommended that the following provisions be made:

"a) Each *county* shall be able to elect from its membership no more than its proportionate share of the total number of delegates in the *councilor* district.

"b) If a county does not have within its boundaries the 15 members necessary to secure a delegate's seat, that county may combine with another county *(or counties)* for the purposes of electing a delegate.

"Under the plan, every component society or combination thereof whose membership is 15 or more shall be able to elect a delegate if it chooses to do so. In addition, each component society has the opportunity to nominate physicians to run as delegates at large."

And be it further,

- Resolved, That in line with the foregoing, the Society use the interval between now and the next meeting of the House of Delegates, to bring to the attention of the general membership by various means, e.g., mailings, regional meetings, councilor contacts, etc., the mechanics and implications of this proposal and invite for the benefit of the delegates who will be voting on the measure this Fall as much grass roots reaction as possible.

The October meeting of the House of Delegates will be at the Hotel Fort Des Moines. The schedule calls for an opening session of the full House at 4 p.m. Friday, October 12. The Reference Committee will hold open hearings the morning of Saturday, October 13, and the concluding full session of the House will be Sunday morning, October 14.

Doctor's Business

by LARRY E. LEAVERTON

STATISTICS—IMPORTANT BUT SOMETIMES MISLEADING

The need for accurate records and statistics is becoming more and more a part of the business side of medical practice. For example, precise information is needed in phases of the Economic Stabilization laws which cover fee increases and allowable salary increases. Fees for Medicare and Medicaid are profiled by percentile for the amount of payment. Frequent references are made to the Cost of Living Index, unemployment rates and other statistical studies. These factors are causing most physicians to become more familiar with statistics pretaining to their practices.

Among the most frequent questions we are asked are ones that deal with percentages of profit margins and permissible increases in fees. As this is written there is a total 60-day freeze on medical fees. While this will undoubtedly be relaxed, total de-control is unlikely. Under the previous phases 2 and 3 an aggregate fee increase of 2.5% was permissible only if the profit margin decreased from the base period. The base period was defined as the profit margin of the best two years of the last three years through the most recently completed fiscal year. The overhead percentage (percentage of expenses to gross income) for the average physician will average from about 35% to 45%. This means the profit margin would be 55% to 65%. Overhead percentages of course will vary depending on the type of practice and specialty. A heavy office practice requiring an extensive layout and a large staff will have higher overhead than for example, a surgical specialty with smaller space and personnel requirements. Some doctors faced with increasing costs such as rent, supplies and salaries are surprised to find their profit margin is stable or even increased because of increased productivity. Others, already operating at peak production, found the rising costs of their practice had lowered their profit margin and should have some relief through fee increases.

Percentages can be misleading. Some doctors are too concerned about their percentage of overhead—to the point where they will hesitate to upgrade the caliber of their office assistants, renovate their office, purchase new furniture or equipment, or move their office to a convenient location, for fear of increasing their overhead percentage. Frequently such a move will actually decrease their overhead as a percentage of gross income due to increased productivity. Another example of misleading percentages is the case of a new physician faced with the decision of joining Group A or Group B. Starting salaries and other factors are comparable but Group A plans to bring the new associate in at 80% of an equal share of profit after the first year. Group B promises an equal share. In analyzing both proposals Group A could be the better offer because of the higher net income of this group. Where a group retirement plan is involved both the percentage of compensation and the projected income at retirement must be examined and considered.

In the case of the practicing physician, both professional and non-professional income should be increasing sufficiently to keep up with inflation. The Consumer Price Index has increased 5.5% over the past 12 months. This means your net income must increase this per-

(Please turn to page 446)

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.



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INFLUENZA VACCINE

Influenza occurs to some extent in the United States every year, but its incidence and the areas affected are quite variable. Periodically, influenza appears in epidemic form. This seems to occur when the antigens of prevalent influenzaviruses change sufficiently to render the population susceptible. Type A and type B influenzaviruses both undergo changes in their antigens. Such changes usually occur gradually, but they can be rapid and abrupt. Epidemics caused by type A influenzaviruses are more frequent and are generally more severe than those caused by type B.

Inactivated influenza vaccines* have not been uniformly effective in the past, and whatever protection they afforded was relatively shortlived. Current vaccines contain more antigen than products available before 1972 and should provide good protection against influenza when the prevalent viruses are identical or similar to those in the vaccine.

Influenza vaccine should be given to chronically ill patients and to older persons in general. These 2 groups appear to be at greatest risk of becoming severely ill with influenza. Because some influenza occurs every year, annual vaccination of "high-risk" patients is indicated as a routine procedure regardless of the amount of influenza expected in any specific geographic area.

INFLUENZAVIRUS VACCINES

Bivalent Vaccine

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Bivalent influenza vaccine this year will contain a new type A influenzavirus representative of currently prevalent "England" strains. Each adult dose of the 1973-74 vaccine will contain not less than 1000 chick cell agglutinating (CCA) units of antigen in the following proportion: 700 CCA units of a type A strain comparable to the prototype, A/England/42/72 (H3N2),† and 300 CCA units of a type B strain, B/Massachusetts/1/71. Vaccines from all producers are highly purified and should be relatively free from adverse reactions.

Monovalent Type B Vaccine

Since late 1972, new strains of type B influenzavirus have been identified as the cause of characteristic influenza illness. They appeared first in Hong Kong in December 1972 and have since been recovered from influenza cases in Australia and England. It is too early to judge whether these strains will generally supplant currently prevalent type B viruses in the United States in the 1973-74 influenza season. However, it is reasonable to expect that they may become widely disseminated.

Since these type B antigens differ considerably from prior strains, little natural immunity to them can be expected to exist in the general population. Likewise, the available bivalent influenza vaccine cannot be expected to give optimal protection against them.

Anticipating the possibility that these type B influenzaviruses will become widely prevalent in the United States, the Bureau of Bio-

* Official name: Influenza Virus Vaccine, Bivalent.

† The World Health Organization has recommended a revised system of nomenclature for type A influenzaviruses which includes their strain designation and a description of the 2 surface antigens, hemagglutinin (H) and neuraminidase (N).

logics prepared guidelines for production of a monovalent type B influenza vaccine containing an antigen representative of the new strains. This monovalent vaccine is expected to be commercially available prior to the 1973-74 influenza season. It should be used as a supplemental vaccine for optimal protection of persons at high-risk who are already recommended to receive bivalent vaccine.

VACCINE USAGE

General Recommendations

Annual vaccination is recommended for persons of all ages who have such chronic conditions as 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; 2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, bronchiestasis, and emphysema; and 3) diabetes mellitus and other chronic metabolic disorders.

Annual vaccination is recommended for older persons because influenza outbreaks are commonly associated with excess mortality in older age groups.

Vaccinating persons who provide essential community services may also be considered if local priorities justify. However, before undertaking such programs, those responsible should take into account a number of reasonable constraints: difficulties inherent in predicting influenza epidemics, variability in vaccine effectiveness, cost, availability of vaccine, and the chance that vaccine will be diverted from persons with chronic illnesses who are at particular risk.

Schedule

The primary series of bivalent influenza vaccine has traditionally been 2 doses. Preliminary data indicate that with the more potent influenza vaccines available in recent years, the second dose provides little additional benefit. It is therefore reasonable to give a single dose of vaccine for either primary or annual booster vaccination. (Dose volumes for adults and children and the recommended route of administration are specified in the manufacturers' package labeling.)

A single dose of the supplemental monovalent type B influenza vaccine should follow and not be given simultaneously with bivalent vaccine. This is because the additional amount of antigen in the monovalent product might increase the chance of adverse reaction. Furthermore, separating the vaccines by 2 weeks or more might enhance an overall type B antibody response.

Influenza vaccination should be scheduled for completion by mid-November.

Precautions

Influenza vaccines are prepared from viruses grown in embryonated eggs and ordinarily should not be administered to persons clearly hypersensitive to egg protein, ingested or injected.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Sept. 13-15	Iowo Society of Anesthesiologists
Sept. 14-16	Third Annual Diologue for Physicions ond Hospital Administrotors (Lake Okoboji)
Sept. 14-16	Reunion Meeting, Closs af 1948
Sept. 19	Poge County Medical Society (Shenandaoh)
Sept. 19-20	Conference on Pediotrics
Sept. 21-22	Postgraduate Canference in Urology
Sept. 24-27	Cardiology Todoy
Sept. 26	Deoling with Emergencies (Broodlawns Hospitol, Des Moines)
Sept. 26	Diet Theropy U.S.A.
Oct. 3	Whot's New in Stroke?
Oct. 4-6	Orthopedic Alumni Meeting
Oct. 4-6	Atherasclerosis Center Workshap an Endothelium
Oct. 5-6	Dermatalagy for the Dermotalagist
Oct. 6	Iowa Acodemy of Ophthalmalagy and Otoloryngology
Oct. 11-13	Antibiotics and Infectian/Course in Infectious Disease

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."



United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report,* the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

COMMON SENSE— IS IT TEACHABLE?

In a recent talk delivered to the Association of American Medical Colleges, Dr. Ivan Bennett, Jr., dean and director of the New York University Medical Center, enumerated six broad factors that represent, in his opinion, what medical education should involve. They are: integrity, intellectual ability, capacity for work, common-sense and judgment, an ability to ascertain the truth, and the acquisition of knowledge. Does it sound like *your* medical education?

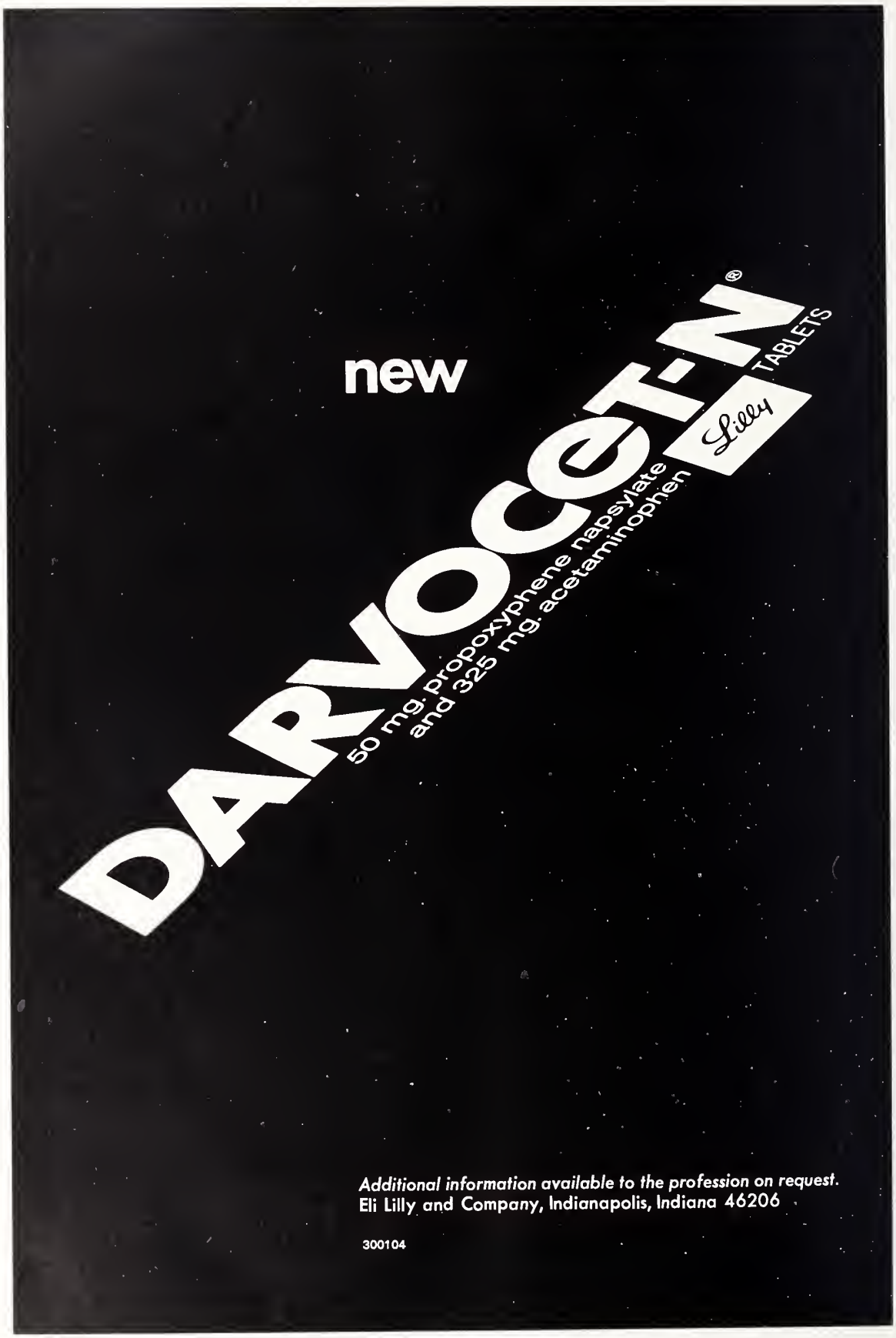
Perhaps his list of factors might be considered characteristics which an admissions committee should seek among its pool of applicants. That sounds good, although perhaps tough to accomplish. It also implies that if the average entering student at age 22 has these characteristics, he will continue to have them and manifest them throughout his career.

Is that last assumption reasonable? Or should a medical school faculty somehow address itself to the cultivation or maintenance of the attributes on Dr. Bennett's list? I suspect most schools and faculty members currently focus their attention on the acquisition of knowledge, and too often ignore or take-for-granted the other aspects. And then what happens regarding the mature practitioner? Almost all effort in providing or receiving continuing medical education focuses on the acquisition of knowledge. The obvious fact that knowledge and behavior may be discordant, and often are, is frequently quoted. The developing national concern for documentation of high quality care may lead to some closure of the knowledge-behavior gap. Yet none of this addresses itself directly to the question of continuing education that attempts to increase integrity, intellectual ability, capacity for work, common-sense and judgment, or ability to ascertain the truth. If these are, as Dr. Bennett asserts, a large part of what medical education is all about, then shouldn't there be efforts to deal with these factors in the curriculum of continuing education? If in fact we do not, is it because we think they don't matter, or that practitioners already have the attributes in abundance, or that they are not learnable or improvable by adults, or that we don't have the know-how to teach them? Are we truly doomed to accept the idea that these valuable traits are either inborn or definitely established at some age prior to becoming a practitioner?

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

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SCIENTIFIC ARTICLES

The Role of Antiepileptic Blood Levels In the Treatment of Patients With Epilepsy

RICHARD W. FINCHAM, M.D., and
DOROTHY D. SCHOTTELIUS, Ph.D.
Iowa City

EPILEPSY HAS BEEN ESTIMATED to occur with an incidence of at least 0.5 per cent in the general population. At least 50 per cent of the patients with this disorder will respond well to conventional doses of anticonvulsant drugs and do not constitute a major management concern. Another 20 to 30 per cent will respond with fairly good although not complete seizure control. Less than a fourth of the patients with epilepsy will be difficult to control with the presently available drug therapy. This latter sub-group of individuals provides a substantial therapeutic challenge. It is in this group that antiepileptic blood levels may be helpful in either achieving better control or in establishing the limits of effectiveness of the drug or drugs being used.

Clinical Approach to Therapy

A program of anticonvulsant therapy is established after the diagnosis of epilepsy has been confirmed. For adults this will usually include a choice of three preparations: phenobarbital, diphenylhydantoin (Dilantin®) or primidone (Mysoline®). It is usual to start with a standard dose of a single drug since any idiosyncratic response then can be promptly attributed to that particular drug and since it may well be possible to attain a satisfactory control of the patients' seizures with a single preparation. A significant number of patients will respond well to this therapeutic approach as shown by the control of their seizures.

Another group of patients will not demonstrate a satisfactory response to a single drug and the physician may choose either to increase the dose of this drug while watching for the signs of toxicity (such as increased drowsiness, mental changes, or ataxia) or he may decide to add a second and rarely a third antiepileptic drug. The patients' response to therapy will again be appraised in terms of seizure control or developing toxicity. A compromise is often reached between partial seizure control and some toxicity in difficult to control patients.

The Role of Antiepileptic Blood Levels in the Clinical Approach

Anticonvulsant blood levels can be particularly useful in working out a schedule of

Dr. Fincham is associated with the Department of Neurology and Dr. Schottelius with the Departments of Physiology and Biophysics and Neurology in the College of Medicine at The University of Iowa. This study has been done in collaboration with the Neurosensory Center which is supported by Program-Project Grant No. NSO3354 of the NINDS.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER, 1973.

TABLE 1

Drug	Therapeutic Level	Toxic Dose	Serum Half-Life
Diphenylhydantoin (Dilantin)	10-20 μg/ml	Above 30 μg/ml	22 hr
Primidone (Mysoline)	4- 8 μg/ml	Above 10 μg/ml	6.5 hr
Phenobarbital	10-30 μg/ml	Above 30 μg/ml	96 hr

Values obtained from "Antiepileptic Drugs" Edited by D. M. Woodbury, J. K. Penry and R. P. Schmidt, Raven Press, New York, 1972.

drug therapy for that group of patients whose seizures prove most difficult to control. The initial single drug may be followed by its clinical effectiveness and this may be correlated with the blood level of the drug being employed (Table 1).

Low Blood Levels

Ineffective control of seizures with a low blood level suggests a number of possibilities:

1. The patient may not be taking the medication.
2. There is poor absorption of the medication.
3. There is some abnormal state of drug metabolism—perhaps on the basis of multiple drug interaction.

If the medication is being taken and is not producing an appropriate therapeutic serum concentration the dose may be increased until the desired range of blood level is attained. If a blood level for the ingested drug attains a concentration in an expected therapeutic range and the patients' seizures do not improve the assumption may be made that the drug is not going to be effective without increasing the dosage to a level which produces a major toxic condition.

At this point the possibility of a progressive underlying disorder, e.g., tumor, infection or metabolic disease, should be reconsidered. If these conditions appear unlikely, combined antiepileptic drugs may be used, and again the clinical response may be compared with the patients' blood levels; the serum levels then providing an important additional objective measure of the therapeutic program.

High Blood Levels

A converse situation may appear in which abnormally high blood levels of antiepileptic drugs are present. This situation is usually marked by clinical signs of toxicity although it appears that toxic blood levels of some anticonvulsant drugs, in some cases, antedate the clinical appearance of toxicity by several months. The physician is usually concerned with excessive doses of anticonvulsants in this setting although drug interactions may bring about this problem in some instances. Rarely, abnormal metabolic breakdown of the anticonvulsant drug (as in instances where parahydroxylation enzymes are deficient in diphenylhydantoin metabolism) can lead to very high and toxic blood levels with quite low doses of anticonvulsants. Appropriate management of these situations includes a reduced dose of anticonvulsant, alteration in concurrent medication schedules, and the use of other antiepileptic drugs following discontinuation of the drug with a toxic blood level.

Normal Blood Levels

The 50 per cent of patients with seizure disorders who respond with good control to conventional doses of anticonvulsant drugs do not require blood level determinations for their routine management. A point however can be made for obtaining one blood level from these individuals after they have been well established on their satisfactory program of medication. The antiepileptic drug level or levels obtained will indicate the amount of drug that satisfactorily controls that individual. If other medications are added at a later time and the patients' seizures do not remain under control a recheck of the patients' blood levels will show if drug interaction has brought about a decrement in the previously satisfactory anticonvulsant blood levels. Should toxicity appear this should be apparent with toxic levels of antiepileptic drugs. Instances of poor control in patients with blood levels comparable to previously effective levels might indicate a need to reappraise the etiologic diagnosis—perhaps to look again for brain tumor. Hence it is desirable to obtain one anticonvulsant blood level from well controlled patients.

CASE REPORTS

Instances of Toxic Blood Levels

Case 1. A 28 year old female patient with a long standing problem of seizures related to a porencephalic cyst was admitted to the hospital

for readjustment of medication. Dilantin® toxicity (ataxic gait to the point of inability to walk and nearly inarticulate dysarthria) was suspected. Her daily medications included phenobarbital 60 mg qid, and Dilantin® 100 mg tid.

Serum antiepileptic blood levels were determined and showed the following values: phenobarbital 66 μg/ml and Dilantin® 17 μg/ml. The diagnosis was appropriately changed to phenobarbital intoxication and the dose of phenobarbital was reduced to 30 mg tid. The toxic state disappeared. The half life (time to clear one-half of the drug from the serum) of phenobarbital (Table 1) indicated a prolonged period of time for recovery from the toxic state. Seven days elapsed between the time of dose reduction and the regaining of the ability to walk.

Case 2. A 50 year old lady was receiving Dilantin® 100 mg tid for a newly developed problem of seizures. She complained that she was feeling dizzy and more drowsy than she had when taking the Dilantin® on a 100 mg bid schedule. The Dilantin® blood level was 32 μg/ml. Plans were made to reduce the Dilantin® dose to 100 mg bid and to recheck the blood level in another month.

Case 3. A 28 year old female patient had been treated with a daily dose of Dilantin®, 350 mg, in order to control previously difficult to manage seizures. A previous blood level of Dilantin®, 12 μg/ml, had been obtained with a 300 mg per day schedule. One month after the increased dose was begun the blood level was 54 μg/ml but because the patient was well controlled the daily Dilantin® dose was not changed. A recheck one month later showed a blood level of 55 μg/ml and no clinical evidence for toxicity. The dosage schedule was not altered. One month later the patient was reported to be ataxic and the Dilantin® was reduced to 300 mg/day and the ataxia disappeared. The subsequent blood level for Dilantin® was 25 μg/ml. Satisfactory seizure control was managed with the concurrent use of phenobarbital 30 mg tid.

Case 4. The concurrent use of multiple antiepileptic drugs may enhance the potential for the development of toxic states. This is illustrated in the instance of a 27 year old patient who was both drowsy and ataxic. Medications included Dilantin®: 300 mg/day, Mysoline®: 875 mg/day, and phenobarbital: 60 mg/day. The patient's blood levels were as follows: Dilantin® 16.5 μg/ml, Mysoline® 6 μg/ml, and phenobarbital 75 μg/ml.

Case 5. A further instance of drug interaction is seen in the situation of a patient with anticonvulsant intoxication. Initial blood levels for phenobarbital and Dilantin® were respectively 66 and 17 μg/ml. The patient was then receiving phenobarbital 240 mg/day and Dilantin® 300 mg/day. The phenobarbital was reduced to 90 mg/day and the Dilantin® was maintained at 300 mg/day. Blood levels determined 14 days later showed a serum phenobarbital value of 30 μg/ml and a Dilantin® level of 11 μg/ml. The decrement in the Dilantin® blood level took place without a reduction in the dose of Dilantin® suggesting that this reduced blood level might be related to metabolic changes associated with the decreased phenobarbital ingestion.

Low Blood Levels

Case 6. A patient with a long standing seizure disorder had never responded well to his antiepileptic therapy. A determination of his blood level on a 100 mg tid schedule of Dilantin® showed the serum level to be 2.5 μg/ml. The oral dose of Dilantin® was increased to 100 mg qid and the blood level increased to 8.2 μg/ml. The seizures continued and the oral dose of Dilantin® was increased to a total of 500 mg/day which brought about a serum level of 15.5 μg/ml and was associated with improved seizure control.

Normal Antiepileptic Blood Levels and Poor Seizure Control

A patient with difficult to control and long standing psychomotor and generalized seizures was seen for an intensive effort at readjustment of the patients anticonvulsant program. After several months of effort in which optimal blood levels for various anticonvulsants were obtained the patient's seizures were only a little better controlled. An adequate blood level will not provide an assurance of seizure control but it will allow the physician to determine that an adequate trial has been given to the particular anticonvulsant drug or drugs so tested.

SUMMARY

Anticonvulsant blood level determinations

afford a rational approach to the treatment of convulsive disorders. Patients with toxic levels of anticonvulsant drugs can be managed with more insight as the drug dosages are reduced and readjusted. Individuals who require more than the usual dose of antiepileptic drug may be more easily recognized and treated. There are, to be sure, limitations to the application of anticonvulsant blood levels to the care of epileptic patients but clearly this testing affords objective data beyond the patient's report of seizure control. This may be of crucial importance to satisfactory management of patient seizures.

Spontaneous Perforation of the Esophagus (Boerhaave's Syndrome)

CHING L. CHIU, M.D., and
RONALD R. GAMBACH, M.D.
Iowa City

A 78-YEAR-OLD WHITE MALE with a two-day history of violent vomiting accompanied by progressive upper abdominal and chest pain was brought to The University of Iowa Hospitals. He had been treated by his local physician with antiemetics for 24 hours prior to being transferred due to his deteriorating condition. His past medical history included chronic obstructive lung disease with no cardiac problem. He had been seen at the urology clinic six days prior to admission for a routine follow-up visit. At that time, he was in his usual state of health with no gastrointestinal or pulmonary complaints. Chest x-ray revealed a normal heart and mediastinum but chronic pulmonary emphysema.

PHYSICAL EXAMINATION & LABORATORY FINDINGS

Upon arrival the examination revealed an acutely ill, thin, elderly Caucasian male with a dulled sensorium. He was diaphoretic, hypotensive and tachypneic. His skin was violaceous, mottled and cool. Subcutaneous crepitus was present in the neck. His temperature was 37.5 C, blood pressure 80/40 and pulse rate of 140. Chest examination revealed bilateral rhonchi. The heart rhythm was regular with no heart murmur or extrasound. The abdomen was firm, tympanitic and nontender without mass or organomegaly. Bowel sounds were extremely hypoactive. Laboratory values revealed slight anemia (RBC: 4.3, Hb: 13.1, Hct: 37%) and moderate leukopenia (2500/mm^3). Serum electrolytes revealed normal Na, K and Cl. CO_2 was decreased (16). Serum amylase (500 with normal 80-150) and SGOT (85 with normal 7.5-40) were elevated. Blood gases showed a low PO_2 of 56 and pH of 7.04 with high pCO_2 of 71.5. Urinalysis was not remarkable. Electrocardiogram showed slight ST-T elevation.

RADIOGRAPHIC FINDINGS

The admission chest radiograph showed air within the mediastinum behind the heart and extending into the neck bilaterally (Figure 1). Abdominal radiograph in supine position (Figure 2) demonstrated an air collection in the lower mediastinum. Otherwise, the bowel findings were unremarkable. The patient was admitted to the intensive care unit. Intravenous 5 percent glucose in water and normal saline with sodium bicarbonate and antibiotics were given immediately and followed by whole blood transfusion. Oxygen was administered in high concentrations by mask. A Hypaque (sodium diatrizoate) esophagram demonstrated an esophageal perforation. The patient was immediately taken to the operating room where a laparotomy was performed for closure

The authors are associated with the Department of Radiology at The University of Iowa College of Medicine.

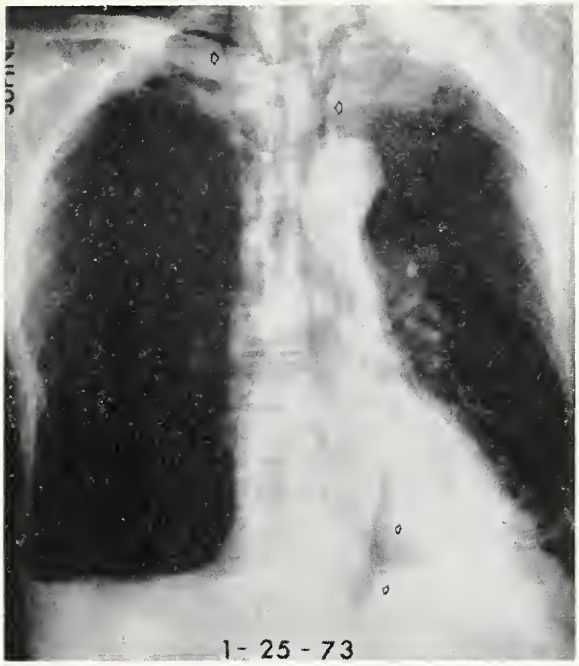


Figure 1. The admission chest in supine position shows air within the mediastinum behind the heart and extending up into the neck bilaterally (open arrows).



Figure 2. The abdominal radiograph in supine position demonstrates an air collection in the lower mediastinum (closed arrows) which clearly outlines the descending aorta (open arrows).



Figure 3. The post-mortem examination revealed a 3.5 cm linear perforation through the posterolateral wall of the esophagus with partial surgical closure.



Figure 4. View of the lung specimen from the back. There were extensive acid coagulation changes over the medial pleura of the left lung with similar changes on the lower right.

of the esophageal laceration and drainage of the mediastinum.

OPERATIVE FINDINGS

At the time of laparotomy, there was a linear perforation of the distal esophagus at the esophagogastric junction located on the left posterolateral portion of the esophagus. The mediastinum was full of foul-smelling necrotic material, gastric juice and air. Both pleural cavities contained a bloody pleural effusion. There was purulent exudate in the abdominal cavity. The stomach was collapsed and empty. The laceration was sutured and the fundus of the stomach was then wrapped around the area of perforation as a Nissen fundoplication. Mediastinal drains were placed.

CLINICAL COURSE & PATHOLOGIC FINDINGS

Postoperatively the patient required adrenaline drip to maintain his blood pressure and respiratory assistance. His cardiovascular and respiratory status continued to deteriorate. Twenty hours after admission, he was noted to have a flat ECG and was pronounced dead. The post-mortem examination revealed a 3.5 cm linear perforation through the posterolateral wall of the distal esophagus with surgical closure (Figure 3), mediastinitis and pneumomediastinum secondary to esophageal rupture. The remainder of the esophagus and stomach were normal. There were extensive acid coagulation changes over the medial pleura of the left lung with similar changes on the right limited to the lower lobes (Figure 4). A blood culture was negative. Generalized emphysematous changes with blebs were present in the apices of both lungs. The coronary arteries showed atherosclerotic changes, none of which were occlusive. The abdomen was flat. Five hundred cc of amber peritoneal fluid was obtained and generalized peritonitis was present.

DISCUSSION

Boerhaave's syndrome or spontaneous perforation of the esophagus[1, 2] has been a known entity since its first description by Hermann Boerhaave in 1724. This has been reported to occur with vomiting,[3] coughing, childbirth, defecation, weight lifting, status asthmaticus, epileptic seizure and from a blow on the abdomen.[4] The mechanism of rupture proposed has been increased hydrostatic pressure in the lower esophagus due to fluid under tension. This exceeds the tensile strength of the esophageal wall which results in perforation.[5] A tear limited to the esophageal mucosa has been termed Mallory-Weiss syndrome. Ninety percent of perforations occur in the left posterolateral wall of the distal third of the esophagus. The mortality rate has been reported to increase with lengthening delay in establishment of the diagnosis and approach 90 percent with a delay of 48 hours.[6] The reported mortality rate with a delay of 12 hours was 25 percent. Thus, early diagnosis with surgical closure of the rupture and drainage of the mediastinum are of the utmost importance.[7, 8, 9]

SUMMARY

A case of Boerhaave's syndrome (spontaneous esophageal perforation) presumably secondary to vomiting is presented. The duration of time between the occurrence of the perforation and diagnosis is uncertain, but the history suggested at least 36-48 hours. The patient was in shock and moribund upon arrival at the hospital. Surgical repair of the ruptured esophagus and drainage of the mediastinum had been performed, but the patient remained in a state of intractable vascular collapse and died within 24 hours after admission. The importance of early diagnosis and treatment of this condition is emphasized.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

FAMILIARITY BREEDS CONTEMPT

An ancient Aesop fable about the fox and the lion presents the admonition that "familiarity breeds contempt." There are multiple facets in the connotation of these three words. A thorough study of a particular subject may reveal aspects that are not acceptable. First impressions may seem favorable; then after a time may be repulsive. Of course it may be the other way around too. So it is in our relationships with patients.

For several years I have corresponded with an English lady regarding our mutual interest in antique infant feeding devices. My English friend recently spent some time in the United States, and during her travels had the misfortune to become ill. Her major complaint of the physician who attended her was that he "called me by my first name within minutes of my entering his office!" (She also felt "his account was pretty staggering.") This lady is the wife of a family physician, so is not a disgruntled lay person who resents the medical profession.

Perhaps this was a poor first impression by one who is more reserved in her life style. Perhaps the physician in question was a buoyant extrovert. Nevertheless those first impressions can cause misunderstanding. In our public relations we must strive constantly to consider persons in individual ways. Often we are criticized because of the actions of our employees. A person who does not feel well does not appreciate an unsympathetic receptionist. An older person may be offended by a young flippant nurse. Even the physician may create a bad impression by his manners. You may say, "so what; such is life." Yet do you really mean that? There is a basic human trait, the desire to be liked and appreciated, and physicians are no exception.

Some patients appreciate a casual, homey, carefree attitude by their physician. Others prefer a strict professional attitude. I once had an interesting discussion about professional status with a pediatrician who practices in New York City. It was impossible for him to believe a professional stature could be maintained while attending patients if a physician were not attired in a dark conservative suit, white shirt, necktie, black shoes, etc. Furthermore, he felt it most inappropriate for anyone, including personal friends, to call him by his first name when in his office or at the hospital. The professional status would be torn asunder by such action. Now this may be going too far, but there is food for thought here. There is a middle road. There is a need for proper action in our relationships with patients. These attitudes will vary from community to community, as well as from individual to individual. The over-friendly, over-familiar attitude may be fine with some—others will prefer their physician to be more "professional-like." Be yourself, but for some patients it may be necessary to vary the attitude.—M.E.A.

DIABETIC RETINOPATHY STUDY

Diabetic retinopathy has become one of the four most common causes of blindness in the United States. Although photocoagulation has been employed in its treatment for more than 10 years, there is still controversy regarding its true value. In spite of the need for objective evidence, an adequately controlled trial to evaluate photocoagulation in the treatment of proliferative diabetic retinopathy has not been performed. This is not surprising, considering the complexity and expense of a large scale clinical trial in any chronic disease. However, as Inglefinger[1] has aptly stated, "When serious diseases are treated by serious methods . . . then ethical as well as scientific considerations require that medicine depend on the most reliable and the best controlled data available—the kind of data that is sought by randomized clinical study."

In keeping with this admonition, a randomized clinical trial of photocoagulation in the treatment of proliferative diabetic retinopathy has been designed and launched. This study (called the Diabetic Retinopathy Study, or DRS) involves 16 Clinical Centers in various parts of the United States, a Coordinating Center at the University of Maryland and a Fundus Photograph Reading Center at the University of Wisconsin, all supported by contracts from the National Eye Institute, a part of the National Institutes of Health.

The support of the medical and ophthalmological communities is needed to carry this study to a successful conclusion. The DRS investigators are, therefore, grateful to the editors for giving them this opportunity to summarize the major features of the DRS and to appeal for the support of all physicians who care for diabetic patients.

The principal eligibility criteria for the Diabetic Retinopathy Study are:

1. Visual acuity with best correction of 20/100 or better in each eye.

2. Diabetic retinopathy in each eye defined as any one of the following:

a) proliferative retinopathy in each eye;

b) proliferative retinopathy in one eye, non-proliferative retinopathy in the other eye;

c) severe non-proliferative retinopathy in each eye.

3. No prior treatment with photocoagulation or pituitary ablation.

4. Both eyes suitable for photocoagulation treatment.

5. The outlook for survival and availability for five years of follow-up must be good. (Patients 70 years of age or older are not eligible.)

6. Only patients willing and able to give their informed consent after thorough explanation of all aspects of the study will be admitted.

The basic question which the DRS has been designed to answer is: can photocoagulation help to prevent severe visual loss due to proliferative diabetic retinopathy? The chief criterion of success will be the degree to which visual acuity is maintained, although visual fields and the morphologic appearance of the retina in stereoscopic color and fluorescein photographs will also be assessed. In order to give all patients enrolled in the study the chance to benefit from photocoagulation, if it is helpful, while minimizing the risk of harm, if it proves deleterious, photocoagulation treatment will be limited to one eye of each patient. This arrangement gives each patient the best chance of retaining vision in at least one eye, the goal of greatest importance to him.

The eye to be treated and the treatment modality to be used (xenon arc or argon laser) will be selected by a random process. Treatment will be carried out meticulously according to a detailed protocol, with central monitoring of post-treatment photographs. Each patient will be followed for a minimum of five years. The pooled results from all 16 centers will be followed closely by the Coordinating Center and presented at frequent intervals to a committee charged with the responsibility of continually monitoring the data for evidence of beneficial or harmful effects. If it becomes evident during the course of the study that photocoagulation is better than no treatment in a certain stage of diabetic retinopathy, patients with untreated eyes in that stage will be offered treatment. On the other hand, if any fea-

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[1] Inglefinger, F. J.: The randomized clinical trial, New Eng. J. Med. 287:100-101, 1972.

ture of either treatment technique proves harmful, this aspect of follow-up treatment will be discontinued. Results of the study will be reported promptly to the scientific community.

All 16 Clinical Centers are now enrolling patients and each is eager to fill its quota of 100 to 150 patients as rapidly as possible. The overall goal of the study is 1800 patients enrolled and treated by July, 1974.

It is important to all ophthalmologists, as well as to the entire medical community, that this controlled study be successful in recruiting the number of patients required to determine if and when photocoagulation therapy should be employed as a treatment of proliferative diabetic retinopathy. It may be many years before facilities and funds will again be available if this opportunity is lost. The DRS Investigators ask for the help of all physicians near DRS Clinical Centers in explaining the study to prospective patients and providing them an opportunity to be considered for participation in it. The sooner we have solid information to guide our treatment of this distressing manifestation of diabetes, the better it will be for its unfortunate victims.

The University of Iowa Department of Ophthalmology, University Hospitals, Iowa City, Iowa is one of the 16 clinical centers selected for this collaborative study.—MATTHEW DAVIS, M.D., *Clinical Director, Diabetic Retinopathy Study*

Morbidity Report for July

Disease	June 1973	1973 to Date	1972 to Date	Most July Cases Reported From These Counties
Amebiasis	4	15		Dallas
Ascariasis	1	4		Page
Brucellosis	1	4		Tama
Chickenpox	41	10767	6431	Scattered
Conjunctivitis	2	800	640	Des Moines, Muscatine
Cytomegalovirus infection	1	4		Scott
Encephalitis, viral	2	7	5	Clinton, Davis
Erythema infectiosum	3	1340		Clay
Gastrointestinal viral infection	42	5278	4247	Scattered
Giardiasis	3	10		Iowa, Polk
Hepatitis, infectious	13	145	175	Scattered
Hepatitis, serum	4	26	41	Greene, Johnson, Linn, Worth
Hepatitis, type unspecified	3	9		Black Hawk, Polk, Woodbury
Herpes simplex	2	38		Johnson
Herpes zoster	2	9		Cass, Union
Impetigo	2	205	19	Dubuque, Linn
Infectious mononucleosis	9	462	576	Scattered
Influenza-like illness	15	11383		Scattered
Meningococcal meningitis	2	18		Jackson, Wapello
Meningitis, aseptic	1	5	1	Linn
Meningitis, bacterial	2	4	2	Marshall, Scott
Meningitis, type unspecified	1	13	8	Fremont
Mumps	29	3002	5659	Scattered
Pediculosis	3	99		Cerro Gordo, Grundy, Linn
Pertussis	14	18	31	Tama
Pneumonia	50	714	552	Scattered
Rabies in animals	17	152	236	Scattered
Rocky Mountain spotted fever	2	6	1	Clayton, Polk
Rubella	3	197	379	Black Hawk, Des Moines, Scott
Rubeola	4	277	711	Des Moines, Palo Alto
Salmonellosis	22	92		Scattered
Shigellosis	28	173		Scattered
Streptococcal infections	200	4550	4543	Scattered
Tuberculosis, active	16	81	69	Scattered
Tuberculosis, inactive	2	15		Clinton, Linn
Venereal disease				
gonorrhea	416	3348	3566	Scattered
syphilis	36	234	286	Scattered

IOWA MEDICAL MISCELLANY

(Continued from page 421)

PRECEPTORSHIP PROGRAM . . . Harold Moessner, M.D., has assumed from Richard Caplan, M.D., administrative directorship of The U. of I. College of Medicine Preceptorship Program. Dr. Moessner is an assistant professor in the Department of Family Practice and is a past president of the Iowa Academy of Family Physicians. Dr. Moessner will be assisted by the departments of internal medicine and pediatrics as well as by members of the IMS Preceptorship Committee.

INSTANT LITERATURE SEARCH . . . Computer access to the Index Medicus tapes from 1970 to the present is available through The U. of I. Health Sciences Library. MEDLINE is particularly valuable for literature searches involving more than one facet or concept and are thus too time consuming for manual searching. Nominal charge is made, usually from $5 to $8. Findings are sent to the requestor as promptly as possible. For more information write or call (319/353-5776) The U. of I. Health Sciences Library.

SPECIAL GIFT . . . IMS officers have accepted a gift from the Schering Corporation in the form of seedling from the sycamore tree under which Hippocrates reputedly lectured to his students. The sapling is from a seed of the famed Tree of Hippocrates on the Island of Cos.

REPORTING . . . Among guidelines approved by IMS House to cover the termination of pregnancy was one emphasizing need for reporting of legal induced abortions. State Department of Health was named agency to be responsible for collection of data and preservation of confidentiality. IMS Subcommittee on Maternal and Child Health has met with SDH officials to advise in development of this reporting program. Subcommittee has urged physician cooperation.

PRAISE . . . State Department of Health Immunization Specialist James Thompson praised Iowa physicians in a recent presentation to IMS Subcommittee on Maternal and Child Health. Thompson cited good physician cooperation in year's measles immunization programs about the state.

FALL CONFERENCE . . . October 17 is date of Iowa Health Council fall conference at Des Moines Hyatt House. Intended for interested representatives of the 10 IHC member organizations (which includes the IMS), the conference includes presentations on PSRO, medical manpower and chiropractic.

STUDENT REPORT . . . U. of I. medical student Doug Hiza thanked IMS, Scanlon Foundation and Prouty Company at last Executive Council meeting for funding provided to support Iowa representation at the national SAMA convention. Hiza was elected to the SAMA board and to the student section of AMA.

SPEAKER . . . Fred Allman, M.D., Atlanta, Ga., has consented to keynote 1974 Sports Medicine Conference to be presented April 4 by the Society and the Iowa High School Athletic Association. Dr. Allman is an orthopedic surgeon widely known for his work with athletes.

EMERGENCY SERVICES . . . State categorization of emergency medical services (into 4 classifications) and legislative backing for the use of "certified mobile intensive care paramedics" are proposals under study by the IMS Committee on Emergency Medical Services. Society support for the categorization is being sought by the Governor's EMS Advisory Council. The Iowa Heart Association and the State Department of Health are seeking backing for the CMICP legislation.

MENTAL HEALTH . . . Representatives of the Mt. Pleasant and Clarinda mental health institutes and the Oakdale treatment facility met August 15 with the Subcommittee on Psychiatric Care to outline their service programs.

PENAL CARE STUDY . . . Special committee on health care in correctional institutions authorized by the House of Delegates met initially in July and will confer again this month. Committee plans a questionnaire to the several state facilities plus site visits to the extent possible. E. M. Smith, M.D., Des Moines, is the chairman.

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

University Drug Letter

by M. M. GHONEIM, M.D.

FLURAZEPAM (DALMANE®)— A NEW HYPNOTIC

Flurazepam hydrochloride (Dalmane®) is a new hypnotic agent belonging to the benzodiazepine class. Chemically it is 7-chloro-1-[2-(diethylamino) ethyl]-5-(0-fluorophenyl)-1,3-dihydro-2H-1,4-benzodiazepine-2-one dihydrochloride. Sleep laboratory studies and controlled clinical trials have confirmed its effectiveness in inducing and maintaining sleep as compared to a placebo. Few studies are available, however, which evaluate it in comparison to other hypnotics. Kales and his colleagues studied the effectiveness of 1,000 mg of chloral hydrate, 500 mg of glutethimide (Doriden®) and 30 mg of flurazepam in insomniac subjects over a two-week period of drug administration and a 22-night protocol. Their results were favorable to flurazepam. Chloral hydrate and glutethimide significantly enhanced sleep induction, but this effect lasted for only several days to one week. Neither drug had an effect on sleep maintenance. Flurazepam, on the other hand, significantly enhanced both sleep induction and maintenance and these effects persisted throughout the two-week period of drug administration. Jick and his colleagues compared the efficacy of flurazepam and secobarbital in a randomized double-blind study by administering a different hypnotic on each of two consecutive nights and asking the patients on the third day which hypnotic produced superior sleep. While there was no difference between 15 mg flurazepam and 100 mg secobarbital the patients showed a clear-cut preference for 30 mg flurazepam as compared to the 100 mg secobarbital.

The drug usually induces sleep within 22 minutes and maintains it for seven to eight hours. It does not significantly suppress rapid eye movements (REM) of sleep (in 30 mg dosage) as do secobarbital and many other hypnotics but reduces stage 4 sleep. The clinical importance of this differential effect on REM sleep is doubtful.

To my knowledge there are no well-controlled studies of the effect of the drug in man on the "same" or "next day" levels of performance to compare it to other hypnotics. The fact that following withdrawal, a carry-over effect remains in terms of sleep induction and maintenance, makes this a subject worthy of pursuit. Evaluating the period of drug withdrawal, flurazepam might have advantages over other hypnotics, notably the REM suppressants. The absence of REM sleep rebound and the presence of carry-over effect may facilitate a smooth transition through the withdrawal process.

The exact site and mode of action of the drug are unknown. In the cat, it reduced the pressor response to electrical stimulation of the hypothalamus and increased the arousal threshold to stimulation of the amygdala and hypothalamus, areas of the brain involved in emotional activity. Reduction of the latter would aid the production of sleep. Flurazepam has anticonvulsant, muscle relaxant and taming properties in animals. These properties, however, have not been evaluated in man. The acute cardiovascular effects of flurazepam in dogs and cats are minimal. High intravenous

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Dr. Ghoneim is an associate professor in the Department of Anesthesia at The University of Iowa College of Medicine. This discussion has appeared previously in the DRUG LETTER, a monthly intramural publication of University Hospitals, prepared jointly by the Pharmacy Department and the Clinical Pharmacology Committee.

doses cause only fleeting vasodepressor effects. In hypertensive rats, large sedative doses cause a moderate reduction of blood pressure. In a chronic tolerance study in man a maximum dose of 200 mg daily was reached by 9 subjects. While subjective side effects were common, systemic toxicity attributable to the drug was not observed.

Absorption, distribution, biotransformation and excretion: Flurazepam is well absorbed after oral administration. Results of studies with flurazepam labelled with 14_C in rats demonstrated that it is widely distributed throughout all tissues with no apparent accumulation of drug or metabolite in any particular tissue. It is rapidly and extensively biotransformed in the body before elimination. Metabolism has been demonstrated *in vitro* using rat and dog liver enzyme preparations. Presumably the liver is also operative as a major site of metabolism *in vivo*. Until now the metabolism has been investigated in two dogs and in four human subjects using 14_C-labelled drug in one study and the pure chemical and its pharmaceutical formulation in the other. Flurazepam is metabolized by successive N-dealkylation of the side chain. The major metabolite in man is the hydroxyethyl derivative. Another one is the N-desalkyl metabolite which is further degraded to the 3-hydroxy analog. The latter does not appear in the urine until the second day and is excreted relatively slowly as the glucuronide conjugate. The hydroxyethyl metabolite has a plasma half-life of about two hours while that of the N-desalkyl one is about 19 hours. It is likely that the latter may accumulate in the plasma on repeated administration of flurazepam. After one oral dose, approximately one-fourth of the 14_C level in the plasma is still present after 50 hours. Since some of the metabolites may be pharmacologically active, further investigations are needed to study the effect of repeated administration as well as overdosage. The major avenue of excretion is the kidney. The human subjects eliminated over 80% of the oral dose in the urine as metabolites.

Preparations and dosage: Flurazepam hydrochloride (Dalmane®), is supplied in capsules containing 15 and 30 mg. The usual adult dosage is 15 to 30 mg before retiring. In elderly or debilitated patients therapy should be initiated with 15 mg until individual responses are determined.

Therapeutic use and relative cost: The drug may be useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. However, its effectiveness over prolonged periods has not yet been established. It may be prescribed in patients who do not respond adequately to other well tried hypnotics or who are allergic to or cannot tolerate them.

The cost of 100 capsules of flurazepam (Dalmane®, 30 mg) to our Hospital Pharmacy is $4.84, whereas that of pentobarbital (Nembutal, 100 mg) is $1.62 and the cost of 100 capsules of secobarbital (Seconal, 100 mg) is $1.57.

Adverse reactions: The incidence and type of untoward effects caused by flurazepam are similar to those produced by other agents in this class. Dizziness and ataxia have occurred, especially in elderly or debilitated patients. Headache, heartburn, nausea, vomiting, diarrhea, constipation, nervousness, residual sedation ("hangover"), talkativeness, apprehension, irritability, weakness, palpitations, and arthralgia have been observed less frequently. Hyperhidrosis, flushes, difficulty in focusing, blurred vision, faintness, hypotension, shortness of breath, pruritus, rash, eosinophilia, dryness of the mouth, bitter taste, excessive salivation, anorexia, slurred speech, confusion, and paradoxic reactions (e.g., excitement, euphoria, hyperactivity) have occurred rarely. All of these adverse reactions have been readily reversible when the dosage was reduced or the drug was discontinued.

Depression of the CNS is dose-related; there is great variability among patients. Failure to appreciate this phenomenon may mean overdosing the sensitive patient. This normal variation among the general population becomes still more important when advanced age or severe debilitating disease complicate the situation.

Drug interactions: CNS depressants are additive when combined; thus the dose of a hypnotic like flurazepam should be reduced when combined with other depressants e.g., alcohol, opiates, tranquilizers . . . etc. Cross-tolerance between these agents has also been observed.

Barbiturates and some other hypnotics may enhance the metabolism of other drugs by inducing the microsomal enzyme system in the liver. In man, phenobarbital has been shown to increase the metabolic degradation of various drugs including bishydroxycoumarin, diphenylhydantoin and griseofulvin. Accordingly, when it is added or subtracted from the therapeutic regimen of a patient receiving a coumarin anticoagulant drug, more frequent prothrombin determinations and adjustments in the dosage of the anticoagulant should be made. Although a four-day treatment of mice with flurazepam did not affect hexobarbital sleeping times, more studies are needed particularly in man to examine its enzyme-inducing capability. Chronic administration of barbiturates and glutethimide enhance their own rate of metabolism, due to enzyme self-induction. Studies with flurazepam are lacking in this regard. The inhibition of drug-metabolizing enzymes by monoamine oxidase inhibitors, adrenergic blocking agents and some others may potentiate the action of hypnotics which undergo extensive metabolic inactivation in the liver. The possibility of such a response with flurazepam should be anticipated.

There is little clinical evidence about the response to hypnotics of patients taking CNS stimulants, e.g., amphetamines. It is possible that the dose of the hypnotic may need alteration in such cases. However, the interaction can be more complex. In individuals taking large intravenous doses of methamphetamine, the sedative-hypnotics (particularly the barbiturates) intensified the aggressive and violent behavior caused by amphetamine.

Physical and/or psychological dependence: As with any new drug, adequate data are not yet available to evaluate these phenomena. Caution must, however, be exercised in its administration to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative.

Precautions: The drug should be used cautiously in patients with impaired liver function. This applies particularly to cumulative doses when the rate of metabolic inactivation would determine the duration and depth of hypnotic action. Patients should avoid undertaking activities that require mental alertness, judgement, and physical coordination, e.g., driving a car, operating machinery, after taking the drug. Although studies in rats and rabbits have suggested no teratogenic effects, the safety of the drug in pregnant women has not been established. It should not be given to pregnant women. Because of a lack of clinical investigations, the response of children to the drug is unknown.

Poisoning: Symptoms of overdosage include somnolence, confusion, and coma. Death from overdosage has not been reported. The management of overdosage follows the general therapeutic measures in cases of acute poisoning. Those include maintenance of a clear airway, immediate gastric lavage and support of the respiratory and circulatory systems when needed. The value of dialysis has not been determined. The drug and its metabolites can be assayed in the blood and urine by spectrophotofluorometry and spectrophotometry.

Conclusions: Flurazepam (Dalmane®) is an effective hypnotic agent. The drug is more expensive than barbiturates and other hypnotics, but appears so far to offer less risk of lethal overdosage. Due to its recent introduction, physicians should watch closely for adverse reactions. The latter's nature or incidence cannot be reliably predicted either by laboratory testing in animals or human clinical trials. More studies are needed of possible residual depression of the central nervous system after wakening, of the biologic activity of its metabolites and of the drug's enzyme-inducing capability in man.

DOCTOR'S BUSINESS

(Continued from page 426)

centage to stay even with the economy.

There are some good aspects of all of this mandatory recordkeeping. It has caused all of us to be more aware of the costs of practice and to search for ways to be more productive.

Percentages, averages and other statistics must be comparable and put in the proper frame of reference. The classic example is the statistician who drowned in a pool where the water was four feet deep, on the average.

The Question Box



by MRS. M. D. HAYDEN

Mrs. Hayden became president of the Woman's Auxiliary to the Iowa Medical Society in April. Her husband, Milford D. Hayden, M.D., practices family medicine in Cherokee.

The physician's wife is likely to be one of her community's busiest persons. In what ways can she best be supportive of her husband and the profession of which he is a part?

It is important for her to be well informed, not about medical treatment, but about health care delivery, and the changes which are proposed, legislatively and otherwise. When she speaks of health care and medically related subjects people assume she is expressing the philosophy of her husband and the medical society, thus she has an obligation to be well informed.

You've obviously found satisfaction in being involved in Auxiliary activities. What aspects have been particularly gratifying?

There are many meaningful activities in which physicians' wives may participate, either individually or collectively; let me emphasize there is variety from which to choose. I am a member-at-large (my county isn't organized) but I have been active in several areas, e.g., the Auxiliary loan fund for local girls studying for health careers; securing medical equipment for international health use; using and promoting the WA-AMA package programs which aid various organizations in conducting numerous public service projects; plus the worthwhile AMA Education and Research Foundation. I do appreciate the information in the state and national publications.

What briefly are the goals of the Auxiliary?

To assist the Iowa Medical Society and to improve the quality of life through health education and health services.

Are there any particularly interesting plans for the WA-IMS in 1973-74?

New this year is our Nutrition Committee. We plan to have a national speaker on nutrition at a workshop which is to be held in conjunction with our October board meeting. Mental health is area which is receiving special attention; we are giving particular consideration to the problem of child abuse. We are pleased to have more of our members on the IMPAC board, we recognize that political action and education are important every year.

We assume you would encourage Iowa physicians to urge their wives to consider membership in the Auxiliary?

I certainly would. In this way the wife gains access to information which will make her more knowledgeable and more able to be supportive of her husband's profession. She will receive the national publication, MD'S WIFE, plus monthly issues of the WA-IMS newsletter. She will have the opportunity to be well informed on medical legislation. And she'll have the chance for fellowship with other doctors' wives. All of these will make her a greater asset to her husband and her community. And she can be just as involved as her time and interest will allow.

MUCH DATA IN NEW ANALYSIS OF IOWA PHYSICIANS

A MASSIVE AMOUNT of statistical information about Iowa medical manpower is contained in a 109-page survey report just released by the State Department of Health (SDH). Credit for the compilation of this interesting and worthwhile data book is due Guru S. Bale, Ph.D., and the Records and Statistics Division of the SDH.

In its preface the report acknowledges and expresses appreciation to Iowa physicians for providing the basic information which is drawn together in the reference volume. The assistance of the Iowa Medical Society and the Iowa Society of Osteopathic Physicians and Surgeons is also recognized.

The material contained in the book is based on a survey of physicians licensed by the State of Iowa. The physicians were requested to provide information regarding their age, sex, professional degree, school attended, year of graduation, place of internship and residency, board status, years of practice, type of practice, etc. The survey was undertaken in conjunction with the annual licensure renewal required of physicians.

URBAN TREND

Findings of the survey tend to further substantiate much of the information or assumption which has existed. For example the known migration of the general population and the physician population to larger Iowa communities is corroborated. Six counties in Iowa have 48.8% of the physicians; these are Polk, Johnson, Black Hawk, Linn, Scott and Woodbury. Each of these counties have more than 100 physicians.

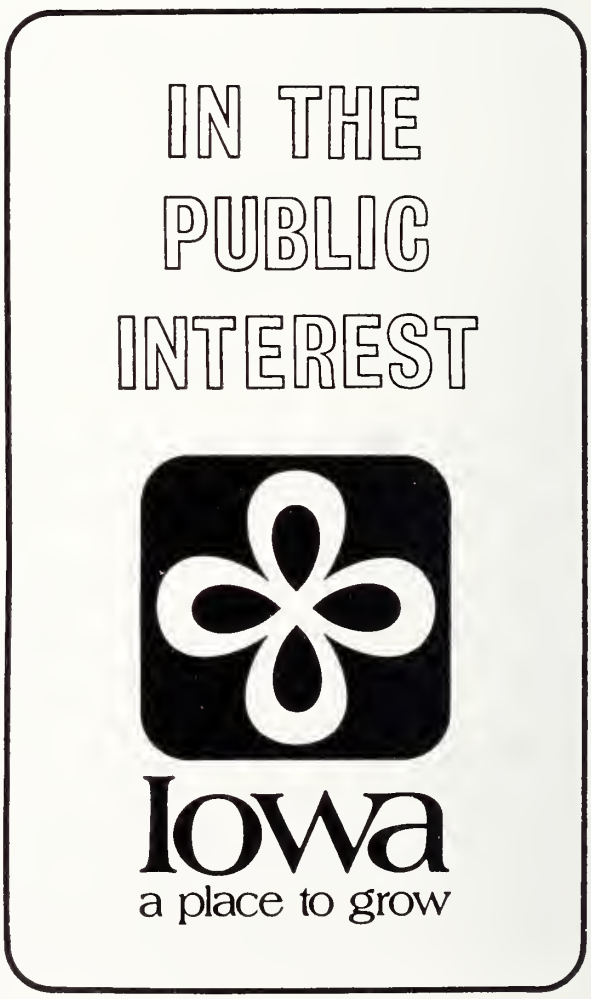
In terms of education, 50.8% (1,474) of Iowa's practitioners have received their degrees from a school in Iowa, 40% from the University of Iowa College of Medicine and 10% from the College of Osteopathic Medicine and Surgery. The two adjoining states, Illinois and Nebraska, have contributed about 9% each to the Iowa physician population. Iowa physicians who were graduated from a school in the United States account for 92% of the total, and 8% were graduated from a foreign school.

Slightly more than 55% of the Iowa physicians, according to the SDH analysis, are specialists. The breakdown of those specialists indicates 57% are certified by a specialty board, another 21% are eligible for certification, and the remainder are general practitioners who limit their practice.

As most observers of health care in Iowa are aware, the specialist physicians are concentrated in population areas which support major hospitals. The survey shows the specialists are found principally in 18 counties. There are 29 counties with no specialists. From the survey a conclusion is reached that shortages are most acute in the specialty areas of pediatrics, internal medicine and obstetrics-gynecology.

AGE FACTORS

In the realm of age 14.2% of the 2,769 active Iowa physicians are more than 65 years of age.



And just under 11% are under 35. Less than 10% of the active specialists are beyond 65 as compared with 21% of the active general practitioners. There are very few (4.4%) specialty physicians under 35 in private practice; this is due in the main to the length of time required for residency, and possibly to time spent in general practice prior to entering postgraduate specialty training. There are 963 specialists in private practice in the age group of 35-64 as compared to 764 general practitioners. The average age of those in private practice is 52.

PRIVATE PRACTICE

Of the 2,904 physicians in Iowa, 77% are in private practice, 18% are not in private practice and the balance are retired. Physicians not in private practice include administrators, physicians in state and federal institutions, residents, researchers, etc.

In terms of educational orientation, the 2,244 Iowa physicians in private practice include 86% graduates of a medical school and 9% who have received training from a school of osteopathic medicine and surgery. Of the physicians in private practice, 52% are graduates of an Iowa school.

Physicians in private practice were found in the SDH survey to have an average length of 20.7 years of practice in Iowa. Nearly 29% has 30 years or more of practice with 21% of these accumulating their years in Iowa.

RATIOS

Reference is made in the survey analysis to the use of population-physician ratios as an index to the availability of physician services. It cites the ratio of 1500:1 as an acceptable standard with any upward trending an indication of inadequate accessibility.

Using the 1970 census figures the survey found 9 counties have a ratio of less than 1000:1, 28 counties have a ratio between 1000-1500:1, 31 counties have a ratio of 1500:1, and 31 counties have a ratio of above 2000:1. Based on the criterion noted in the preceding paragraph 62 counties could be classed as not having physician services sufficiently accessible. In the SDH analysis other criterion is applied (physicians under 65 and in private practice, general practitioners in private practice, etc.) and an obviously higher population-physician ratio develops in most counties.

The survey presents certain basic information on the 16 planning regions in the state. Regional highlights appear below:

---

1) **Allamakee, Clayton, Howard and Winneshiek**—6 hospitals, 42 physicians, 39 in private practice. Average physician age is 53. Population physician ratio is 1763:1.

2) **Cerro Gordo, Floyd, Franklin, Hancock, Kossuth, Mitchell, Winnebago and Worth**—9 hospitals, 146 physicians, 133 in private practice. Average age is 53. Population-physician ratio is 1155:1.

3) **Buena Vista, Clay, Dickinson, Emmet, O'Brien, Osceola and Palo Alto**—10 hospitals, 72 physicians, all in private practice. Average age is 54. Population-physician ratio is 1501:1.

4) **Cherokee, Ida, Lyon, Monona, Plymouth, Sioux and Woodbury**—16 hospitals, 194 physicians, 164 in private practice. Average physician age is 52. Population-physician ratio is 1264:1.

5) **Calhoun, Hamilton, Humboldt, Pocahontas, Webster and Wright**—8 hospitals, 112 physicians, 101 in private practice. Average physician age is 52. Population-physician ratio is 1212:1.

6) **Hardin, Marshall, Poweshiek and Tama**—4 hospitals, 83 physicians, 77 in private practice. Average physician age is 54. Population-physician ratio is 1328:1.

7) **Black Hawk, Bremer, Buchanan, Butler, Chickasaw, Fayette and Grundy**—12 hospitals, 201 physicians, 173 in private practice. Average physician age is 50. Population-physician ratio is 1447:1.

8) **Delaware, Dubuque and Jackson**—7 hospitals, 116 physicians, 110 in private practice. Average physician age is 50. Population-physician ratio is 1184:1.

9) **Clinton, Muscatine and Scott**—7 hospitals, 205 physicians, 188 in private practice. Average physician age is 51. Population-physician ratio is 1259:1.

10) **Benton, Cedar, Iowa, Johnson, Jones, Linn and Washington**—12 hospitals, 623 physicians, 251 in private practice. Average physician age is 49. Population-physician ratio is 1315:1.

11) **Boone, Dallas, Jasper, Madison, Marion, Polk, Story and Warren**—22 hospitals, 620 physicians, 493 in private practice. Average physician age is 51. Population-physician ratio is 1019:1.

12) **Audubon, Carroll, Crawford, Greene, Guthrie and Sac**—7 hospitals, 64 physicians, 59 in private practice. Average physician age is 54. Population-physician ratio is 1556:1.

13) **Cass, Fremont, Harrison, Mills, Montgomery, Page, Pottawattamie and Shelby**—10 hospitals, 139 physicians, 124 in private practice. Average age is 52. Population-physician ratio is 1515:1.

14) **Adair, Adams, Clarke, Decatur, Ringgold, Taylor and Union**—6 hospitals, 43 physicians, 39 in private practice. Average physician age is 53. Population-physician ratio is 1585:1.

15) **Appanoose, Davis, Jefferson, Keokuk, Lucas, Mahaska, Monroe, Van Buren, Wapello and Wayne**—11 hospitals, 132 physicians, 123 in private practice. Average age is 56. Population-physician ratio is 1250:1.

16) **Des Moines, Henry, Lee and Louisa**—7 hospitals, 112 physicians, 100 are in private practice. Average physician age is 52. Population-physician ratio is 1188:1.

About IOWA Physicians

Dr. Mark E. Thomas, Des Moines pediatrician, was guest speaker at recent Child Abuse Workshop in Calmar. The workshop was sponsored by District 14, Iowa Nurses Association, the INA State Community Health Conference Group, and INA Maternal and Child Health Conference Group. . . . **Dr. James L. Knott,** Council Bluffs, has been designated Fellow in American College of Physicians.

Dr. R. J. Coble has closed his private practice of medicine in Lake Park to become director of new post-graduate family practice education program in Mason City. The new residency program is to be established at Mercy Hospital. . . . **Dr. Philip J. Sullivan,** formerly of Overland Park, Kansas, joined the Leon Clinic in July. A 1971 graduate of The U. of I. College of Medicine, Dr. Sullivan interned and had one year of orthopedic residency at Kansas City General Hospital. . . . **Dr. L. A. Gaukel,** Onawa, was recently honored by Burgess Memorial Hospital employees for 40 years of service to Onawa and the surrounding area. . . . **Dr. Herbert Buchsbaum,** associate professor in Department of Obstetrics and Gynecology at U. of I. College of Medicine, is 1973-1974 chairman of Johnson County Chapter of American Cancer Society.

Dr. John O. Eiel, Osage, was honored by Osage citizens at open house marking his 50th year in medical practice. Dr. Eiel received the M.D. degree at U. of I. College of Medicine in 1923 and located in Osage in 1926. A World War I veteran, Dr. Eiel was the first chief of staff at Mitchell County Memorial Hospital and is a life member of the Iowa Medical Society. . . . **Dr. K. V. Shah,** Clarinda Mental Health Institute medical staff member, was recently recognized by the American Medical Association for his program of continuing medical education. . . . **Dr. William R. Wessels,** chairman of the Marshalltown Area Community Hospital board of trustees, noted the rapid advances in local health care, equipment and personnel in a recent talk before the Matins Kiwanis in Marshalltown.

Dr. Mark Thoman, Des Moines, will serve as director of a referral clinic for the diagnosis and care of cystic fibrosis and related lung diseases. Clinic was established recently in Des Moines in cooperation with the Iowa Chapter of the National Cystic Fibrosis Research Foundation and Iowa Lutheran Hospital. . . . **Dr. Lloyd E. Caauwe,** West Point, was honored recently by the West Point Community Club. A "Doctor Caauwe Night" was held to show the community appreciation to Dr. Caauwe for locating and maintaining a full time office in West Point. . . . **Dr. James Habermann,** Fort Dodge pathologist, will head hospital board charged with consolidation of two Fort Dodge hospitals—Bethesda General and Mercy. Dr. Habermann has worked closely with the study committee working for consolidation of the two hospitals. . . . **Dr. L. Robert Martin,** director of medical education at Mercy and St. Luke's Hospitals in Cedar Rapids, recently announced an arrangement which will provide training opportunities for seven young physicians in Mechanicsville. The Pioneer Medical Clinic in Mechanicsville will be staffed by doctors in the family practice residency program sponsored by St. Luke's and Mercy. The seven physicians will serve the Clinic on a rotating basis with 24-hour coverage provided.

Drs. Dwayne Howard; Robert A. Boldus; John W. Scott; Charles M. Marriott; A. Akbari and **John A. McFarlane,** all Sioux City physicians,

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participated in a recent paraurological seminar for nurses at St. Luke's Medical Center in Sioux City. . . . At June annual meeting of medical staff of Cherokee Mental Health Institute, the following physicians were elected—**Dr. R. D. Brundage,** president; **Dr. E. A. Kjenaas,** vice president; **Dr. David B. Winstein,** D.O., secretary; and **Dr. B. Frank Vogel,** chief of staff. . . . **Dr. Sam T. Donta,** assistant professor in Department of Internal Medicine at U. of I. College of Medicine, has been awarded a $48,661 two-year grant from the National Institute of Allergy and Infectious Diseases for study of cholera toxin's effect on adrenal cells in tissue culture.

Dr. Don E. Boyle, Sioux City, has been named president of Woodbury County Heart Association; **Dr. H. E. Rudersdorf,** Sioux City, is vice-president. . . . At annual meeting of Mid-Central States Orthopaedic Society, Inc., **Dr. Dale G. Phelps,** Waterloo, was named associate member; and **Dr. Peter D. Wirtz,** Des Moines, active member. . . . **Drs. Leonard H. Boggs** and **Earl Mumford,** Sioux City, were elected to board of directors of St. Luke's Medical Center at recent annual meeting of Lutheran Hospital Association in Sioux City. . . . **Dr. J. C. Justin,** Mason City, was guest speaker at recent meeting of Mothers of Twins in Mason City. Dr. Justin's topic, "Who's Likely to Have Twins and Why."

Dr. and Mrs. F. C. Perkins, Hedrick, attended reunion of U. of I. College of Medicine Class of 1928 in Iowa City. There were 22 physicians present from nine states. . . . **Dr. Charles A. Johnson,** Sioux City, attended recent postgraduate course on Intensive Care Management of Trauma Patient at Harvard University. . . . **Dr. Charles J. Krause,** associate professor of otolaryngology and maxillofacial surgery at U. of I. College of Medicine, recently served three weeks at mission hospital in Chungathara, India, with a cleft palate team sponsored by Rosemont (Pa.) Church of the Good Shepherd. . . . **Dr. James L. Knott,** Council Bluffs, and **Dr. Charles P. Burns,** Iowa City, were recently named Fellows of American College of Physicians. . . . **Dr. Stuart W. Leafstedt,** Sioux City, was elected to membership in Society of Head and Neck Surgery at recent meeting in Hot Springs, Virginia.

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Dr. Thomas R. Viner, Leon, was recently elected to Board of Trustees of Simpson College in Indianola. A 1943 graduate of Simpson College, Dr. Viner received M.D. degree at University of Nebraska School of Medicine. He is a past president of Simpson College Alumni Association and has been active in Leon Chamber of Commerce, industrial committee, school board and city council and has served on the board of Westview Acres Nursing Home. . . . **Dr. Gary Olson** has joined **Drs. Ed Laird, K. H. Prescott, R. R. Hansen,** and **W. M. Petty** in practice at Buena Vista Medical Clinic in Storm Lake. A 1971 graduate of U. of I. College of Medicine, and former Hawkeye basketball player, Dr. Olson completed his internship and residency in family practice at Broadlawns Hospital in Des Moines.

Dr. Robert C. Thompson has joined **Drs. John J. Shurts,** and **Robert J. Lynn** to do family practice at Eldora Medical Center. Dr. Thompson is a graduate of U. of I. College of Medicine and interned in family practice at Akron (Ohio) General Medical Center. . . . At annual meeting of Cherokee Mental Health Institute medical staff, **Dr. R. D. Brundage** was named president; **Dr. E. A. Kjenaas,** vice president; **Dr. David B. Weinstein,** secretary, and **Dr. B. Frank Vogel,** chief of staff. . . . **Dr. Charles E. Schaefer,** general surgeon with head and neck specialization, has joined the Kuker Clinic in Carroll. Dr. Schaefer has been assistant chief of general surgery service and chief of head and neck section at Letterman General Hospital, Presidio of San Francisco. Dr. Schaefer has 12 years of Army service with 11 months in Vietnam. He received the M.D. degree at University of Kansas School of Medicine, and interned at Fitzsimons General Hospital in Denver, Colorado. He is diplomate of American Board of Surgery, fellow of American College of Surgeons and recipient of AMA Physician's Award.

The St. Luke's Medical Center in Sioux City has new officers: **Dr. John A. McFarlane,** president; **Dr. D. B. Blume,** vice president; and **Dr. E. M. Mumford,** secretary-treasurer. Named members-at-large on the Executive Committee were **Dr. L. H. Boggs** and **Dr. C. A. Johnson.** . . . **Dr. J. E. Whitmire,** Sumner, re-

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We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

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cently received the Rotary Club's "Community Service Award." The award honors Dr. Whitmire for his long membership in the Sumner Rotary Club and for his long medical service to the Sumner community. Dr. Whitmire is the only living charter member of the Sumner Rotary Club (it was organized in 1937). He began his medical practice in Sumner with his father, **Dr. W. L. Whitmire,** in 1928. . . . **Dr. Mark L. Messingham** has joined **Drs. James H. Coddington** and **Maurice L. Northup** in Humboldt. Dr. Messingham is a graduate of U. of I. College of Medicine and interned at Hoag Memorial Hospital in Newport Beach, California.

Dr. Frank Waites is new medical staff member at the Muscatine Community Health Center. Dr. Waites received the M.D. degree at University of Illinois School of Medicine. He has practiced in Elizabeth, Illinois. . . . **Dr. M. D. Enna,** Dumont physician for 25 years, retired from active practice in September. Before locating in Dumont, Dr. Enna spent three years in military service and two years in Rock Rapids. He and his wife have purchased a home in Sun City, Arizona, where Dr. Enna will practice medicine on a limited basis and pursue postgraduate study. . . . **Dr. R. J. Coble,** Lake Park, has been named assistant professor in U. of I. Department of Family Practice, and director, Family Practice Residency Program, St. Joseph Mercy Hospital, Mason City. Before assuming full time responsibilities in Mason City, Dr. Coble will work for three months in the Department of Family Practice in Iowa City. He has practiced medicine in Lake Park since 1955.

Dr. Victor T. Wilson recently joined **Dr. Warren H. Bower** in his Grinnell surgical practice. Dr. Wilson received the M.D. degree at U. of I. College of Medicine and interned at San Bernardino (California) County Hospital. Following Air Force service in Vietnam, where he served as flight surgeon, Dr. Wilson completed a surgical residency at Iowa Methodist Hospital in Des Moines. . . . **Dr. R. L. Sedlacek,** Cedar Rapids, was guest speaker at recent Iowa City area Osteomates meeting. Dr. Sedlacek spoke on "Post Operative Problems of the Ostomate." . . . **Dr. RoseMary Mason** has joined **Dr. H. K. Merselis** in family practice in Audubon. Dr. Mason received the M.D. degree at U. of I. College of Medicine and interned at Royal Victoria Hospital in Montreal, Quebec, Canada. She is the daughter of **Dr. and Mrs. Edward E. Mason.** The senior Dr. Mason is a professor in Department of Surgery at U. of I. College of Medicine.

Dr. Rolando Fernando began a surgical practice in July at Medical Associates in Maquoketa. Dr. Fernando received the M.D. degree at the University of Manila in the Philippines. His residency training has been at Colorado State Hospital in Denver, Colorado; Montfort Hospital, Ottawa, Ontario, and Rogers Memorial Hospital, Washington, D. C. His last year of surgical preceptorship was with Surgical Associates in Mason City. .

DEATHS

Dr. Peter Van Zante, 72, of Pella, died July 9. Dr. Van Zante received the M.D. degree at Rush Medical College. He was associated with several Chicago hospitals and was a practicing obstetrician at Chicago Lying-in Hospital before locating in Pella. Dr. Van Zante was a member of Iowa Medical Society and American Medical Association.

Dr. Thomas F. Suchomel, of Cedar Rapids, died July 15 in a Cedar Rapids hospital. Dr. Suchomel received the M.D. degree at U. of I. College of Medicine. He was a World War I veteran and during World War II, served as state chairman of physician procurement under the manpower commission of the War Department. He also headed the medical emergency section of Linn County civil defense organization. Dr. Suchomel was a past potentate of El Kahir Shrine, and a member of Linn County Medical Society and Iowa Medical Society.

Dr. Douglas Lawson, 41, of Fort Dodge, died July 19 at Mayo Clinic in Rochester, Minnesota. Dr. Lawson received the M.D. degree at U. of I. College of Medicine in 1956 and completed his internship at Mercy Hospital in San Diego, California. Dr. Lawson served in U. S. Army and later in Iowa National Guard. After

returning from service, he joined Department of Radiology at U. of I. College of Medicine and became an associate and member of the staff in 1963. A year later he located in Fort Dodge and practiced radiology at Trinity West Hospital for nine years. Dr. Lawson was a member of Fort Dodge Board of Education; past president of Webster County Tuberculosis and Health Association; and a member of Webster County Medical Society, Iowa Medical Society and American Medical Association.

Dr. F. H. Beaumont, 69, died July 24 at his home in Boise, Idaho. A native of Council Bluffs, Dr. Beaumont received the M.D. degree in 1928 at Jefferson Medical College in Philadelphia, Pa. Following a residency in surgery, Dr. Beaumont located in Council Bluffs in 1931 where he practiced his specialty until his retirement in 1968. Dr. Beaumont was a fellow of the American College of Surgeons; and a member of Iowa Medical Society and American Medical Association.

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Medical Assistants

by TENORA MEYER, CMA

CPR TRAINING SESSION

A feature of the September 29-30 Seminar of Medical Assistants at the Ames Holiday Inn will be a Cardiopulmonary Resuscitation Program by Orrin Hall, M.D., an anesthesiologist, and Jane Hasek, R.N., both of Waterloo.

Dr. Hall is a graduate of Tufts Medical School in Boston, Mass. He has practiced anesthesiology at St. Francis Hospital in Waterloo for 10 years. He is active in CPR work. Mrs. Hasek is State Chairman for Emergency Services and Cardiopulmonary Resuscitation Committee of the Iowa Heart Association. She is employed as supervisor of the In-Service Training Program at St. Francis Hospital.

Mannequins will be utilized in the training sessions. The medical assistants will be divided into groups with an instructor for each group. One instructor will be Mrs. Charlotte Lewis, CMA, of the Waterloo Chapter of Medical Assistants. Charlotte has received special training from the Iowa Heart Association in teaching techniques for closed chest cardiac resuscitation. She was recently chosen as "Woman of the Year" by the Waterloo Business Women's Association.

For the session, it is recommended that slacks or culottes be worn, as this will be a working-training program.

COMPLETE SEMINAR PROGRAM

Saturday, September 29

8-9 A.M.	Registration
8:55 A.M.	Welcome—Sally Gesink, President, AAMA, State of Iowa
9 A.M.	"Administrative Secretarial Review"—Margaret Taylor, Des Moines Technical High School
10 A.M.	"Laparoscopy—Female Sterilization"—Michael Hirsch, M.D., Gynecologist, Des Moines, Iowa
11:15 A.M.	"Hertko Hollow"—Edward Hertko, M.D., Internist, Des Moines, Iowa
12:30 P.M.	Luncheon
1:30 P.M.	"Cardiopulmonary Resuscitation"—Orrin Hall, M.D., and Jane Hasek, R.N.
	Film: Pulse of Life
Dinner	

Sunday, September 30

9 A.M.	"Clinical Review"—Shirley Muehlenthaler, R.N., Des Moines Area Community College
10 A.M.	"Residential Treatment Centers"—Harry Woods, Director, Ft. Des Moines Correctional Center

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Holiday Inn, Ames, Iowa September 29-30, 1973

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NATIONAL AAMA CONVENTION OCTOBER 23-27

A highlight of the AAMA national convention in Washington, D. C., will be a special tour of the Washington Hospital Center's 74-bed Intensive Care Wing, largest in the world. Units in this wing provide special care for: burns, surgery, renal and pulmonary care, medical care, coronary care and psychiatric care. A complete program of the national convention will be printed in the next issue.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

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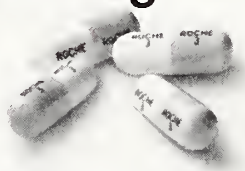
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which follows:

Indications: Relief of a
occurring alone or accompany
states.

Contraindications: Pat
hypersensitivity to the drug.

Warnings: Caution pati
combined effects with alcohol
depressants. As with all CNS-
patients against hazardous oc
complete mental alertness (*e.g.*
ery, driving). Though physica
dependence have rarely been
mended doses, use caution in
addiction-prone individuals c
increase dosage; withdrawal s
convulsions), following disco
drug and similar to those seen
have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

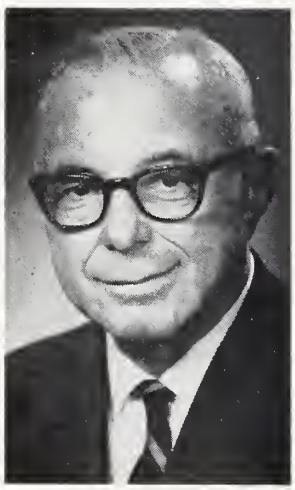
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Valium®
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To help you manage excessive psychic tension

President's Page



October is an action-packed month. First, the IMS House of Delegates is meeting (October 12-14) in Des Moines. Two major items—delegate alignment and fiscal status—are on the House agenda. We hope your county society has discussed these matters and will have its delegates present and voting.

Also, on October 17, the Society, as a member organization, will be involved in the Iowa Health Council Leadership Conference. Health manpower, continuing education, consumerism, chiropractic and PSRO's are conference topics. The session is open to Society members and will be at the Hyatt House in Des Moines.

On October 30-31 the Society will conduct a two-day practice management workshop for senior medical residents about to enter private practice. This joint venture with the AMA will be at IMS Headquarters.

Finally, October is Immunization Action Month nationally. Immunization levels among our nation's pre-schoolers have decreased alarmingly in recent years. Through this October focus and with conscientious follow-up it is hoped a minimum of 90% of the estimated susceptible children (1 through 4) may be immunized against measles, rubella, polio, diphtheria, tetanus and pertussis by the end of their first year of school. Physician support of this kind of effort has been encouraged by the IMS through the Committee on Maternal and Child Health and in cooperation with the State Department of Health.

Here's to a busy October.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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IOWA Medical Miscellany

FALL CONFERENCE . . . Thos. A. Ballantine, M.D., Boston, chairman of AMA Committee on Quackery, will discuss chiropractic and P.L. 92-603 at October 17 Fall Conference of the Iowa Health Council. Session at Hyatt House in Des Moines is open to interested physicians. Other speakers include Israel Light, Ed.D., dean, University Health Services, Chicago Medical School, and Paul Seebohm, M.D., associate dean, U. of I. College of Medicine (both on health manpower); Etta Rasmussen, R.N., assistant dean, U. of I. College of Nursing (on continuing education); Roger Anderson, D.O., member, State Board of Medical Examiners (on consumers on professional licensing boards), and George W. Wells, Chicago, associate director, Health Insurance Council, and J. H. Sunderbruch, M.D., president, Iowa Foundation for Medical Care (on PSRO). Lt. Governor Arthur Neu will present a special luncheon address.

WORKSHOP . . . End of month workshop will be presented October 30-31 at IMS Headquarters for 25 senior medical residents about to enter private practice. Topics include personnel problems, patient flow techniques, physical aspects of the medical office, legal matters, etc. Workshop is co-sponsored by AMA and IMS.

VIET PROGRAM ENDS . . . The Volunteer Physicians for Vietnam program, which was initiated in 1965, was terminated in June. In the eight-year period 10 tours of duty were undertaken by Iowa physicians.

PAY $209 ANNUALLY . . . Average out-of-pocket spending for those Americans with medical costs in 1970 was $209, according to AMA. This is exclusive of payments made by insurance companies, employers, public agencies, etc. In addition, 72% of the household population in 1971 received a doctor's care or advice at least once during the year.

HOUSE BREAK . . . Members of the IMS House of Delegates and their wives will be guests of the U. of I. Medical Alumni Association from 5:30 to 7 p.m., Saturday, October 13 at the Hotel Fort Des Moines. In conjunction with House of Delegates sessions, the social hour is sponsored by the U. of I. Alumni Association in cooperation with the College of Medicine.

HMO APPOINTMENT . . . Marvin H. Dubansky, M.D., Des Moines, has been appointed to an Advisory Committee on HMO's by Iowa Insurance Commissioner William Huff.

BUILDING PLANNING . . . Representatives of the Society and the Iowa Chapter, American Institute of Architects, are inviting Iowa Hospital Association to share in production and distribution of a summary of planning principles important in the construction of health facilities. IMS Committee on Architectural Education has guided project to near completion.

EVALUATE SURVEY . . . IMS Committee on Medical Education and Hospitals met August 29 to review findings of recent random survey of Iowa physicians to determine needs and desires in realm of continuing education. A report on this subject will be presented to the House of Delegates.

NAMED . . . Robert A. Pfaff, M.D., Dubuque, has been named to the Health Facilities Construction Review Committee of the State Office of Comprehensive Health Planning.

PHARMACY . . . Ways wherein physicians and pharmacists can increase their joint service potential for patient benefit were discussed in late August by the IMS Committee on Interprofessional Activities and a corresponding unit from the Iowa Pharmaceutical Association.

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	TMP/SMX (1:20) SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Important note: **Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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The Physician and His Relationship to Society

RUBIN H. FLOCKS, M.D.
Iowa City

Robert Louis Stevenson said a century or so ago, "There are men and classes of men that stand above the common herd—the soldier, the sailor and the shepherd not infrequently; the artist rarely, rarelier still the clergyman; the physician almost as a rule. Generosity he has such as is possible to those who practice an art, never to those who drive or trade, discretion tested by a hundred secrets; tact tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. He brings an air of cheer into the sick-room and, often enough, though not so often as he wishes, he brings healing."

The physician has always had a significant place in society. There is no question but that his functions in society are more important today than ever. The vital responsibilities and concerns of the contemporary physician may be categorized as four in number. 1) The provision of scientific medical care; 2) The provision of public health; 3) The provision of scientific research to advance the science of medicine, and 4) The provision of personal care for episodic and chronic illness which is described so well by Stevenson. The latter is important to the individual. He considers it a personal matter. He identifies with "my doctor." It is a quality which people need very much and feel most strongly about when it is lost. It is a dimension we must emphasize intensively in our thinking as we respond to the continuous and rapid change which is characteristic of society today.

In the past 70 years, as a result of scientific and technologic advances, the profession has made giant strides in three of the four functions I have just listed. The public health aspect of our society has eliminated such diseases as malaria, typhoid fever and smallpox, and is actively working to control such problems as pollution. The scientific progress in health care has included the chemotherapeutic and biologic elimination of such diseases as poliomyelitis, bacterial infections, and altered the life history of many malignancies and cardiovascular diseases. The surgery of our time has been altered strikingly. The advent of the organized support of biomedical research by both private and governmental sources in our medical schools has exponentially expanded medical research. All this has created the institutionalization of medical care and has caused: 1) An altered distribution of physicians which has qualitatively changed the interface between the physician and patient; 2) An altered attitudinal relationship of the physician to the patient—the team approach; 3) An increased cost factor in the delivery of medical care, and 4) An increased demand for medical care such as: dialysis, transplantation, newer types of surgery and newer types of diagnostic and therapeutic procedures.

SUPPLY AND DEMAND

Thus, because of these factors, we find segments of society no longer receiving all of the health care which is available today. In addition, because of the dissemination of medical knowledge to the community by improved communications, the demand for health care has intensified and the premise has been articulated that health care is a right of all of our society.

These remarks were presented by Iowa Medical Society President Rubin H. Flocks, M.D., at the May 24 convocation for the 1973 graduates of The University of Iowa College of Medicine. Dr. Flocks is professor and head of The U. of I. Department of Urology.

Thus it has raised the question very strongly—Is the profession so organized that it can provide this new, very excellent care to all in need? This is apparently the so-called health care crisis. It is no longer enough to be well educated, it is no longer enough to advance medicine through research, it is the responsibility of our profession to provide care for all. *This is considered by society a right and the responsibility of the profession to provide.*

What is the nature of the public's expectations and the nature of its understanding of modern medicine? As Alex Gerber points out, "For the youngster with pneumonia, antibiotics have replaced the physician's sleepless vigil." An injection of 400,000 units of penicillin in the buttocks not only stings, but understandably does not engender the same sense of gratitude towards the physician. One cannot quarrel with the technical direction of contemporary medicine—its success is too apparent. Advances in medicine are characterized as simultaneously a glory and a curse; a glory because they make possible miraculous cures and a curse because they make medical care more complex, expensive, less personal, and cause the public to expect miraculous cures to a point where there is a false presumption that failure to recover from any illness must be the doctor's fault. In the words of Robert Chase, "the concept of total freedom from disease as a right and the physician's total responsibility for it is a dangerous social illusion."

CONTROL OF HEALTH CARE

A third factor has entered the picture in a very subtle way. One is not even certain how important a part it plays, but the question has been asked—Is the problem encompassed by the health care crisis being used in a political way by politicians, by nonprofessional health care groups, and by other segments of our society, to create change in our society by the direct or indirect control over the health care industry or system? This has been indicated in discussions by Donabedian entitled, "Directions in Health Care Policy," and by a recent discussion of the problem by Governor Ronald Reagan of California and by others. Donabedian contrasts the motivations distinguishing the health planner and the social reformer. All these influences have their effect upon the public expectations, and it is extremely important in our modern society that these public expectations be within reason. This can only occur with education of the public and all segments of the public, through educated statesmanship and leadership provided by the health care industry. Very important within this is an adequately educated physician. Only by such education will it be possible for us to maintain the flexible, pluralistic type of health care system which can respond adequately to the rapid changes occurring in society, and the rapid developments as a result of the technologic advances coming from basic and applied research.

POSTGRADUATE EDUCATION

As I review and participate in the many urgent activities taking place in medicine today in response to the problems just described, I find the following: There is marked activity in improving medical education and studying means to accredit it. There is much concern that society will try to accredit this much more stringently and rigorously than ever before. This may lead to recertification and has led to relicensure measures in at least two states. Although this is creditable, it is not really hitting at the heart of the problem. The physician in this country is better educated scientifically than anywhere else in the world. Frantic, unplanned and poorly thought-out procedures here may be stultifying to the education of the physician, may lead to the production of technicians rather than a cadre of physicians capable of statesman-like creative leadership. It may actually lead to inferior medical care and to a system of medical care which will be so rigid that it will be unable to respond flexibly and adequately to the rapid changes I have noted. A perfect example of this occurred recently with respect to certification in nuclear medicine.

Many of you probably know this education and accreditation matter has involved the close cooperative endeavors of the following organizations: The American Medical Association, the Association of American Medical Colleges, the Council on Medical Specialty Societies, the American Hospital Association and the American Board of Medical Specialties. These organizations have created a Coordinating Council with subsidiary liaison committees for undergraduate, graduate, continuing educa-

tion, and the education of allied health personnel. This cooperative effort may well lead to a statesman-like, carefully thought-out program of medical education and the accreditation of it by representatives from the previously mentioned five organizations, the federal government and the public. However, and I want to emphasize this, it may lead to an improvement in an area which up to the present time has been the outstanding feature of American medicine and has been better thought out than in any other country in the world.

INCREASING THE NUMBERS

There has been marked activity also to increase the numbers of health personnel by cutting curricula, by the development of allied health personnel and through manpower studies by both the profession and the government. This again is creditable, but it is not hitting at the heart of the problem, which is attitudinal and distribution related, due to the institutionalization of medicine caused by scientific and technologic developments to which one must add, poor education of the public with regard to the nature of institutionalized medical care. Since the problems are vast, it is very important that the education of the physician be broad and deep. Shortening the curriculum will solve nothing, since it will create not physicians but technicians and thus ultimately will lower the quality of medical care available to society.

Family physician programs have been expanded tremendously in recent years. This does hit at one of the important facets—the attitudinal change which has occurred. The family physician, working in settings of out-reach medical education and treatment centers, will tend to attack the altered distribution problem and also the attitudinal one. It is imperative that these be so organized that society participates actively and thus is continuously educated and aware of problems related to the provision of health care. Actually, if the public, and the legislators, would concentrate on these two aspects of our system, all the rest might well fall in place.

In all segments of society within the profession, within private groups and within government, there is much study with regard to costs. It is here that organized medicine has been criticized. An image has been created in some circles that has neglected to emphasize the tremendous contributions of the organized health industry, not only to education and the accreditation of it, but to all facets of the provision of health care to the public. On the contrary it has emphasized increases in cost. Actually, I am sure that, as emphasized earlier, the improvements in health care have far surpassed the increased cost.

The Medicare and Medicaid Laws are constantly being altered to cut costs and are already beginning to endanger many important aspects of medical education and altering the philosophy of "equal care for all," one of the slogans used to sell them to the public. The medical foundations, the HMO's, and the groups for prepaid medical care have been formed to control costs, either through the profit motive or through surveillance techniques. All have many problems because of the real danger that much cost cutting will interfere with one or another aspect of the quality of health care. As one author has said, "The profession has an obligation to assume positive leadership in order to preserve its professional prerogatives and thus be able to provide the best of health care. We must not allow cost cutting to interfere with the quality of medical care."

ATMOSPHERE OF EXCELLENCE

You have just completed the course of study in one of the oustanding medical centers in this country. Dean John Eckstein and John Colloton have done a splendid job, with the help of President Willard Boyd and his central administrative colleagues, in fashioning an institution where there is an atmosphere of excellence in all the departments of the Medical School. They have given you a broad and deep education. They have fostered outreach programs through preceptorships and family practice experiences to give you an understanding of the educational and sociological problems of health care delivery as we know them today. You are to be congratulated.

You are also to be challenged—you must maintain and expand your fund of knowledge. This you can do by continuing to study and participate in the educational outreach programs of the Medical College and the medical societies. You must also confront the challenges raised by the so-called health crisis which have

(Continued on page 496)

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

MEDICAL EDUCATION OF THE PUBLIC

Like it or not, you're a part of the faculty providing medical education to the public. One small bit of a vast and varied faculty, but a part nonetheless. What are your credentials?—that you have a medical degree, or a license to practice, or a "shingle" with your name on it? What objectives and curriculum have you selected for your students? (Are your students only your patients or do you have a teaching responsibility to all your fellow citizens?) How can you tell if your students are learning what they should?

Your fellow teachers include everybody's relatives, all allied health workers, an assortment of home medical encyclopedias, newspaper and magazine articles on health subjects, radio and television reports and commercials, a few physicians who write syndicated question-and-answer columns, myriads of trial and error experiences and zillions of accurate and inaccurate observations and conclusions by essentially everybody.

Your objectives and curriculum? Perhaps to inform and motivate the public sufficiently that venereal disease, dental caries and drug abuse will decrease, while normotension, visual acuity and muscular tone will increase? Or would you accept some of the aspirations of Richard Asher, a notably clear-thinking British physician: "I would like the public to realize that, in general, a little of what you fancy does you good. I would like the public to have a rough idea of what is going on inside them, but not enough to make them hypochondriacal. . . . I would like to see our patients and our public cease their vain strivings after longevity, and to realize that it is better to live for 70 years without fussing, than to achieve the age of 80 with elaborate, painstaking care."*

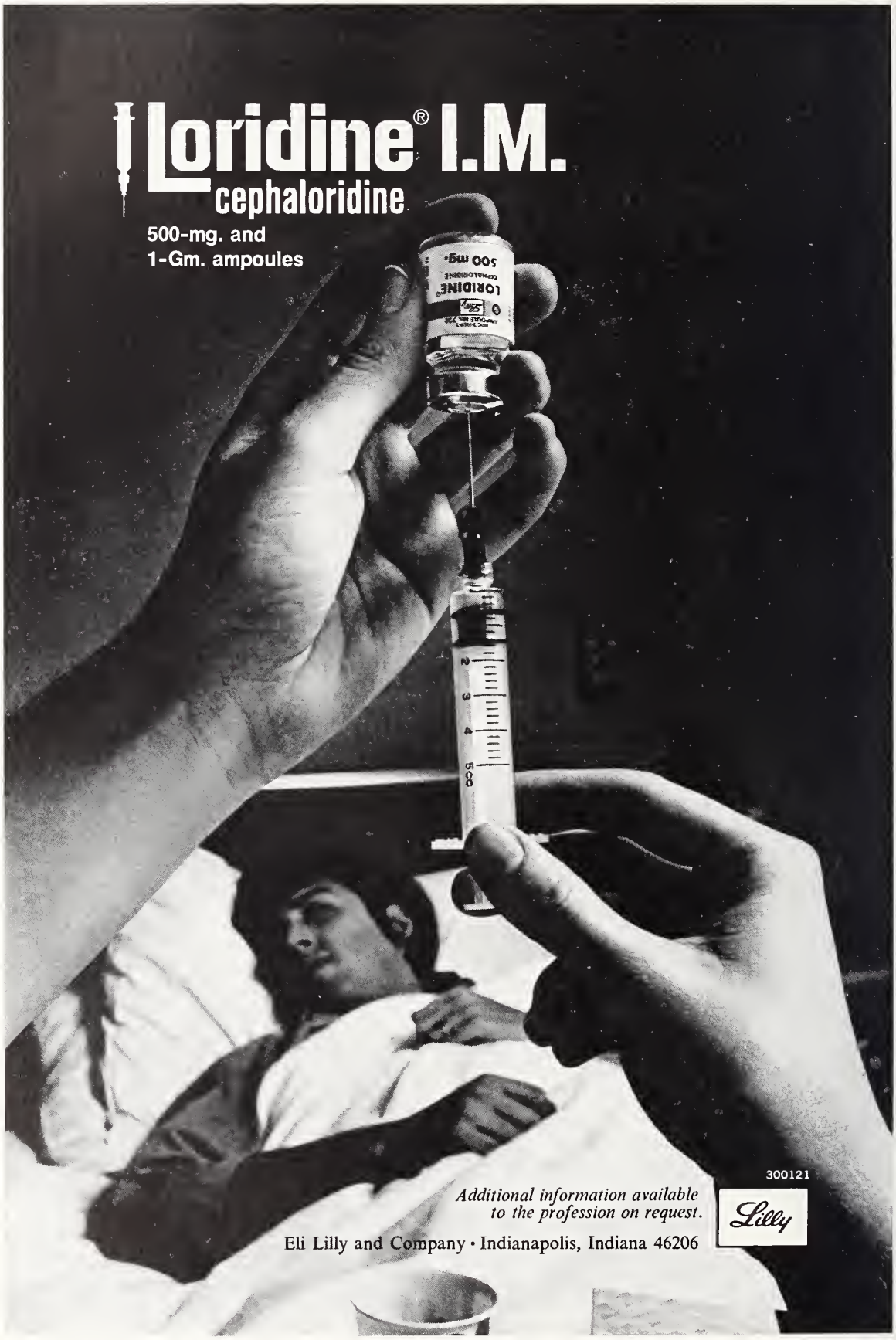
What instructional methods do you favor? Simply telling your patients the medical facts of their problem at the time you see them in the office or hospital? Or providing carefully selected (or personally prepared) readings for your waiting room to supplement HOME BEAUTIFUL and SPORTS ILLUSTRATED? Or arranging opportunities to speak to your community's leaders and non-leaders at PTA meetings, Rotary luncheons, grade school classes, ladies' clubs, church sermonettes? Do you make effort to achieve accuracy of the health information (as you understand it) disseminated by visiting nurses, local pharmacist, or radio station? Do you have a "No Smoking" sign in your office?

Or do you really think that none of what I've been saying properly belongs to your role as you've defined it? Is your reaction to this, "I'm too busy looking at ear drums, snugging up drooping vaginal walls or prescribing ointment to try to be a teacher *too*." If it is, I'm sorry. For in my view your practice could be more exciting, your days more zestful and your total career more productive if you would see yourself as a teacher and perform accordingly. And the entire world would be a tiny bit better.

Does all this express too much messianic fervor about education? If you think so, please forgive me. You see, I happen to like my work. I hope you do, too.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

* *Richard Asher Talking Sense*, ed. by Sir Francis Avery Jones, University Park Press, Baltimore, 1972, p. 109.


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SCIENTIFIC ARTICLES

Which Patients Need Coronary Artery Surgery?

DONALD B. DOTY, M.D.,
NICHOLAS P. ROSSI, M.D., and
JOHANN L. EHRENHAFT, M.D.
Iowa City

Coronary artery disease is one of the major public health problems of the United States. It is estimated that cardiovascular disease accounts for approximately 53% of the total mortality or over one million deaths annually. Ischemic heart disease is responsible for two thirds of these cardiovascular deaths. Extrapolating these figures to the population in Iowa, annual deaths due to coronary artery disease are estimated at 11,000. Furthermore, it is estimated that 3.1 million Americans between ages 18 and 79 definitely have coronary artery disease and another 2.4 million are suspected of having the disease. Somewhat over one million myocardial infarctions occur annually with resulting death in 40%.

The authors are associated with the Division of Thoracic and Cardiovascular Surgery, Department of Surgery, University of Iowa College of Medicine. The paper was presented by Dr. Doty in Cedar Rapids January 4, 1973, at the St. Luke-Mercy Hospitals' Day of Cardiology under the sponsorship of the Cedar Valley Chapter of the Iowa Heart Association.

In recent years, surgical treatment of coronary artery disease has rapidly expanded with the development of methods of direct myocardial revascularization, especially the aorto-coronary bypass operation. Initial enthusiasm has been great, and there has been widespread use of these operations in spite of changing and evolving indications for operation. As new information on the effectiveness of aorto-coronary bypass operations has accumulated, it is appropriate to reassess the place of surgery in the treatment of coronary artery disease, so as to eventually standardize indications for operation.

The history of surgery for coronary artery disease is littered with discarded procedures, all of which had great temporary enthusiasm.[1] Ligation of the internal mammary artery produced relief of angina pectoris in 50% of patients, but so also did a sham operation produce similar results.[2] A number of operations deliberately designed to create pericardial adhesions and various vascular pedicles of skin, omentum, lung, intestine, and the like have also been shown to relieve angina pectoris, but the results have been short lived. Similarly, the operations proposed by Beck to improve myocardial blood supply by coronary sinus stasis have been discarded because of high operative

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER, 1973.

mortality and only short term improvement. Revascularization of the myocardium directly by artificially created vascular shunts such as the Vineburg operation[3] or its modifications received considerable attention prior to 1967 when it was shown that angina pectoris could be relieved in over 70% of patients. The open distal end of the internal mammary artery was implanted into the myocardium. Instead of forming a hematoma, the myocardial sinusoids took up the blood flow eventually making direct small collateral anastomoses with the coronary artery circulation. The flow through these vascular implants has subsequently been shown to be low, averaging 8 ml/min with a range of 4 to 19 ml/min.[4] This operation was essentially abandoned and replaced by newer techniques of direct anastomosis of vascular grafts to the coronary arteries. The internal mammary vessels have been directly anastomosed with coronary vessels for direct revascularization procedures under certain favorable circumstances. The most popular direct operation of this type involves direct anastomosis of a vein graft to the coronary arteries and was accomplished independently by Favaloro and Kahn in 1966-1967.[5]

This operation which places a saphenous vein graft between the ascending aorta and the distal coronary artery to bypass proximal obstruction has been extensively used in many medical centers in numbers presently in excess of 20,000 patients per year. Collected results from large series are shown in Table I. The symptoms of angina pectoris are completely or partially relieved in 95% of patients, but objective improvement in left ventricular function is less reliable.[6] Approximately two thirds of patients are sufficiently improved to return to full time employment.[7] Patency rate of the vein grafts has been determined angiographically and correlates with flow rates in excess of 40 ml/min at the time of surgery.[8] Early patency corresponds to saphenous vein grafts used to bypass femoropopliteal atherosclerotic vascular disease and late patency of 65% at five to 10 years can be anticipated.[9] The main morbidity of aorto-coronary bypass operations is myocardial infarction which occurs in 10-15% of patients.[10, 11] Overall mortality rate is 5-10% for aorto-coronary bypass graft operations. Mortality is related to both case selection and surgical experience with the early series mortality (< 100 cases) about 18%, 200 to 300 cases about 10%, and over 300 cases 2-5%.

TABLE I

CORONARY ARTERY BYPASS OPERATIONS
COLLECTIVE RESULTS

		Per Cent
Angina pectoris	Asymptomatic	70
	Improved	25
LV function	Improved GXT	50
Full time work		67
Patency	Early	85
	One year +	75
Myocardial infarct	Operative	11
	1-30 Months	11
Mortality		5-10

Shows average results of coronary artery bypass operations expressed as percentage compiled from several large series reported in the literature.

The results in any particular institution will, of course, depend upon a number of factors not the least of which are technical: the availability of high quality coronary angiography for accurate diagnosis and a team of operating surgeons capable of achieving reproducible perfection in the technique of bypass graft surgery. Angiography is essential because the location of coronary artery occlusion and the quality of the coronary bed distal to the obstruction must be accurately assessed prior to operation. Evaluation of the coronary circulation at the time of operation is not particularly helpful, and preoperative deliberate planning of the operation based on angiographic findings is required. A combination of cine-angiography (motion picture) and fixed film multiple exposures in several roentgenographic projections is the best means of insuring an accurate preoperative evaluation.

The technical aspects of the operation cannot be overemphasized. The preparation of the saphenous vein graft and its anastomosis to the aorta and the distal coronary artery, which are involved in atherosclerotic disease, require strict attention to detail. The operation should be standardized so it can be performed in a reproducible fashion by all surgeons in the institution. The technical aspects of the anastomosis of the saphenous vein graft to the aorta are shown in Figure 1. The anastomotic area is isolated by a partially occluding clamp

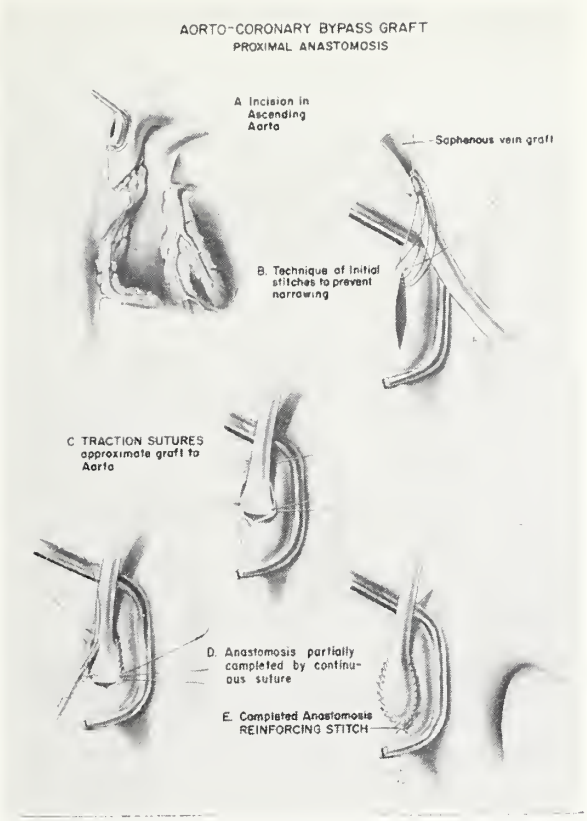


Figure 1. Technical aspects of aorta to saphenous vein graft anastomosis (left coronary type). This step is performed prior to cardiopulmonary bypass using a vascular clamp to isolate only a portion of the aorta. This shortens the period of extracorporeal circulation and facilitiates hemostasis at this anastomosis.

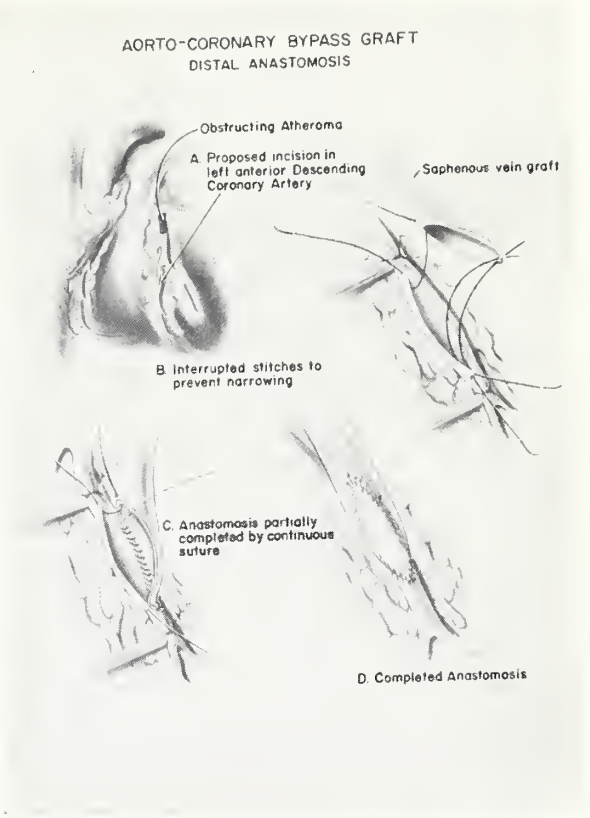


Figure 2. Technical aspects of saphenous vein graft to coronary artery anastomosis (left anterior descending type). Perfection in technique is aided by a quiet heart on cardiopulmonary bypass, interrupted suture in critical areas, and optical magnification.

on the aorta. Fine monofilament suture material (00000 Prolene) is used so that three or four continuous loops can be placed in the heel of the graft prior to approximation of the graft to the aorta in order to prevent narrowing of this critical angle. Traction sutures insure a wide anastomosis and a reinforcing suture prevents splitting of the aorta and consequent blood loss. This portion of the procedure is accomplished prior to establishment of cardiopulmonary bypass which is necessary to quiet the heart motion for the distal anastomosis of the graft to the coronary artery shown in Figure 2. A segment of the coronary artery is isolated with occluding tourniquets distal to the area of obstruction. The saphenous vein graft is approximated to a longitudinal incision in the side of the coronary artery with fine monofilament suture material (000000 or 0000000 Prolene). Interrupted stitches are used distally to prevent narrowing at this critical point and continuous suturing is used through the remainder of the anastomosis to insure hemostasis. Using this technique, functional anastomosis can be made to coronary arteries as small as one mm in internal diameter. Three power magnification aids visual acuity for these small vessel anastomoses.

The most common clinical syndrome for which aorto-coronary bypass operations has been performed is disabling angina pectoris with high-grade obstruction shown angiographically of the proximal portions of the right, anterior descending, or circumflex coronary arteries, singly or in combination, with patent distal vessels. Surgery has generally been restricted to those patients refractory to conventional medical therapy. As mentioned previously, the symptoms of angina pectoris can be reliably relieved in a high proportion of patients. Operable lesions can be expected in a high percentage of patients studied angio-

TABLE II

CORONARY ARTERY BYPASS OPERATIONS

Factors Affecting Mortality
Poor Left Ventricular Function
Congestive Heart Failure
Increased LVEDP (> 25)
Decreased Ejection Fraction
Recent Myocardial Infarction
Location of Disease

The factors listed in this Table are associated with increased operative mortality in coronary artery bypass operations.

graphically. The likelihood of finding obstruction of a major coronary artery in a patient with severe angina pectoris is nearly 90%, and the feasibility of bypass grafting in patients with such lesions is greater than 90%.[12] Dissection studies of pathology specimens show that bypassable lesions are present in nearly all hearts affected by coronary artery disease, but complete bypass of all proximal disease may be possible in only 67% of hearts examined.[13]

If one is to consider surgery which has a mortality of 5-10% for the symptom of angina pectoris, there must be a clear understanding of the natural history and progress of the disease. The largest group of unselected patients with angina pectoris was compiled at the Mayo Clinic.[14] In 6882 cases, there was a mortality of 15% in the first year and 9% per annum thereafter for a five year survival of 58% and 10 year survival of 37%. One of the factors which appeared to increase mortality was an abnormal electrocardiogram, especially those with T-wave and Q-wave changes or conduction disorders which increased annual mortality to 12%. In a 25 year followup study of 456 patients with angina pectoris other cardiac risk factors included cardiac enlargement, hypertension, congestive failure, and myocardial infarction.[15] The Framingham study[16] and the Albany study[17] have clearly shown that smoking, obesity, cholesterol-lipid abnormalities, and family history of coronary disease are also related to increased coronary artery disease risk. From these studies it is concluded that the patient who has severe angina pectoris with abnormal electrocardiogram, possibly with hypertension or an enlarged heart, who smokes and has a serum lipid abnormality and a positive family history for coronary artery disease is at high risk and should be considered for coronary angiography and perhaps aorto-coronary bypass graft surgery.

Once the anatomic diagnosis is established by coronary angiograms and an estimate of left ventricular function is made at catheterization and with left ventricular angiography, further predictions regarding the natural history can be made which can be balanced against the risk of operation. The most important information in this regard is based on the group of patients with angina pectoris studied by Friesinger.[18] There was a very high survival rate (95%) in patients with mild (single vessel) coronary artery disease followed over five years while only 47% of patients with severe (2,3 vessel) disease survived. Angina at rest increased the risk. From these data, it is concluded that aggressive surgical treatment may be justified in severe coronary disease in hopes of improving survival, in addition to improving quality of life by relief of angina pectoris. It is clear that indication for surgery is purely symptomatic in single vessel coronary disease unless the lesion is located in the main portion of the left coronary artery. These very proximal lesions are known to have very poor prognosis when treated medically but also carry an increased operative risk (12%).[19, 20]

Cardiac catheterization findings assist in determining the factors affecting operative mortality shown in Table II. Spencer clearly established increased risk of aorto-coronary bypass operations in patients with congestive heart failure.[21] Total mortality of 37% and only 20% good results show that operation is not helpful once left ventricular function has become so poor that congestive heart failure is the prominent symptom of a patient with coronary artery disease. Left ventricular function can be quantitated by measurement of left ventricular end diastolic pressure and calculation of the ejection fraction from left ventricular angiography. Left ventricular end diastolic pressure greater than 25 mm Hg was associated with 34% operative mortality[22] and ejection fraction 0.26 to 0.45 with a mortality of 30%.[23] When ejection fraction is less than 0.25, operative mortality is prohibitive at 78%.

Acute myocardial infarction increases the risk of aorto-coronary bypass graft surgery. Reul and associates performed emergency coronary bypass operations in 17 patients who had acute myocardial infarction following cardiac catheterization.[7] Eight of the patients died. The rationale for immediate revascularization in these patients is based upon the assumption that while irreversible myocardial necrosis may have occurred, ischemic myocardium adjacent to the area of infarction may be improved.[24] Others have successfully operated following acute infarction, but the electrocardiographic evidence of infarction persists.[25] Operation for acute infarction in the presence of circulatory shock has such poor results even with temporary means of circulatory support such as intra-aortic balloon pumping[26] that expansion of these techniques beyond centers currently involved seems discouraging.

On the other hand, surgical intervention in the pre-infarction angina syndrome offers much promise. The natural history is again important in that there is little difference in survival of these patients with unstable angina pectoris (61% five year survival) compared to ordinary chronic angina pectoris.[27] There is considerable difference if the anginal pain continues at rest in the coronary care unit. These patients with rest angina only have a five year survival of 27% and nearly one half are dead within one year. In addition, 21% of these patients had myocardial infarction within three months. It is not clearly documented that surgical treatment will reduce the incidence of subsequent myocardial infarction and death in these patients, but intuitively revascularization of the ischemic myocardium would seem to have merit. It has been shown that patients with the pre-infarction angina syndrome have the same operative risk as those with chronic angina pectoris.[28] At this institution, an aggressive medical and surgical approach has been taken in patients with unstable angina pectoris, especially those with persistent pain or arrhythmia after hospitalization and appropriate medical therapy. Early cardiac catheterization with coronary angiography followed by urgent aorto-coronary bypass graft operation appears indicated based upon present available information.

It is known that aorto-coronary bypass operations are effective in relieving the symptom of angina pectoris in the patient with coronary artery disease. The symptom is undoubtedly relieved by increasing blood flow and oxygen supply to ischemic myocardium. By relieving pain, there is no question that the quality of life is improved for the patient with coronary artery disease. The really important questions of whether myocardial infarction is prevented or life prolonged or the disease process altered in any way remain unanswered. This information may be several years forthcoming, perhaps not at all because of the spectrum of the disease process and variability of the patient population. Randomized studies have been urgently requested by those skeptical of the operation, but have been countered by the enthusiasts and patients themselves. To date, the best information of this type available is from the Cleveland Clinic.[29, 30, 31] One thousand consecutive patients had aorto-coronary surgery between 1967 and 1970. In the first 300 patients in the group, subsequent myocardial infarction occurred in 3.3%. The entire group has been followed, and the mortality rate determined for up to five years. The average annual attrition including hospital mortality was 4.1% (79.4% five year survival). This was compared with a similar (not random or identical) group of 200 patients who were studied by coronary angiography in a period prior to the availability of bypass graft surgery. These patients all had 80-100% stenosis of proximal coronary arteries and a good distal coronary bed which would have been adequate for coronary revascularization, had operative techniques been available. This group had annual attrition of 6.8% (65.8% five year survival). Patients with three vessel disease only had 50% five year survival which corresponds to data reported by Friesinger.[18] Further evaluation is necessary, of course, before absolute conclusions can be made. Information presently available suggests that there may be improved patient survival in those patients with more severe multiple vessel coronary disease, as well as improved quality of life after performance of aorto-coronary bypass graft surgery.

During the past 12 months a limited number of patients with coronary artery disease

TABLE III

CORONARY ARTERY BYPASS OPERATIONS
University of Iowa Hospital—1972

	Number	Per Cent
Coronary angiography	165	49
Referred to surgery	36	22
Emergency operations	12	33
Mortality	3	8

The results of aorto-coronary artery bypass operations during 1972 at the University of Iowa Hospitals are shown.

have had aorto-coronary bypass graft operations at the University of Iowa Hospitals, as shown in Table III. The size and composition of the patient group reflect both a conservative approach to the patient with chronic angina pectoris and an aggressive treatment program for the patient with pre-infarction angina syndrome. Coronary angiography is performed in about one half of the adult patients during cardiac catheterization, and about one fourth of these patients are referred for aorto-coronary bypass surgery. Of 36 patients operated in 1972, 12 were for emergency indications. There were three deaths (8%), none of which occurred during emergency operations.

SUMMARY

In summary, and in answer to the question: Which patients need coronary artery surgery? it is suggested that patients with chronic or unstable (pre-infarction) angina pectoris refractory to conventional medical therapy be considered for surgical intervention provided left ventricular function is not severely impaired and the coronary vascular bed seems suitable for the procedure. At present, a particularly aggressive diagnostic and surgical approach is advised for the patient with pre-infarction angina syndrome continuing with rest pain under appropriate medical treatment in the hospital. Aorto-coronary bypass graft surgery can be accomplished in such patients with a low surgical mortality and can be expected to relieve symptoms in nearly all of them.

ADDENDUM

Since completion of the original manuscript, the experience with aorto-coronary bypass operations has enlarged at the University of Iowa. During the period extending from January 1, 1972 to September 15, 1973, a total of 195 bypass grafts have been performed in 97

(Continued on page 497)

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Tuberculin Conversion in Junior and Senior Medical Students at the University of Iowa

DAN RANDA and
SERGIO RABINOVICH, M.D.
Iowa City

Exposure to tuberculosis is an inevitable concomitant of the practice of clinical medicine. The magnitude of the hazard involved is, however, a difficult assessment to make as it frequently does not lend itself to clinical investigation. The basic problem is that the unknown cases of active tuberculosis admitted to a ward for diagnostic or other unrelated investigations are more likely to disseminate their disease than known cases under proper care and restrictions.[1] Although direct assessment of the frequency of exposure is not practical, it is possible to approach this problem indirectly. By determining the frequency of conversion to tuberculin skin test antigen in a well defined population, a rough estimate of the degree of exposure to tuberculosis can be determined.

MATERIALS AND METHODS

At the end of the sophomore year, before clinical experience has been obtained, medical students at The University of Iowa are given a Tine test (0.05 mg OT) as a part of their microbiology course. Further evaluation throughout their medical education has been essentially left to the students discretion. Most students apply an intradermal PPD sometime during their rotation through the various clinical services. Those who undergo a conversion (a reaction greater than 10 mm induration to intradermal "intermedium" strength PPD stabilized with Tween 80) frequently seek advice from the clinical staff—usually from the Infectious Disease Department. By means of a short questionnaire mailed to each junior and senior medical student in March, 1971, an estimate was made of 1) the number of tuberculin convertors in the junior and senior class, 2) the frequency of testing for PPD conversion, and 3) the therapy undertaken by those who converted.

RESULTS

Of 277 questionnaires mailed to each member of the 1971 junior and senior classes, 274 were returned—127 seniors and 147 juniors. Results are shown in Table 1. Nine of the 127 senior students who returned the questionnaire indicated they had a positive reaction to the Tine test in the sophomore year (7.1%). Six students in this group attempted to confirm these results with an intradermal injection of intermediate strength PPD. In two of these students the PPD was negative. Of the 118 seniors who did not react in the sophomore year to the Tine test, 103 applied an intradermal PPD on one or more occasions during their junior or senior year. Intermediate strength PPD was applied an average of 2.1 times per person. Second strength PPD was applied only by 11 students on 14 occasions. The average interval since the last test was applied was 6.2 months. Nine of the 103 students converted to a positive reaction (10 mm or more induration). Hence, 8.7% of the senior class converted their two years of clinical work. Only two of the nine can relate an exposure to a patient with documented active tuberculosis. Six of the convertors had a chest film and five are receiving prophylactic INH (isoniazid) for one year.

Mr. Randa was a senior medical student at The University of Iowa College of Medicine when this article was prepared. Dr. Rabinovich is an associate professor in The U. of I. Department of Internal Medicine. The study was supported by a grant from the Iowa Thoracic Society.

TABLE I

DATA ON THE TUBERCULIN STATUS OF JUNIOR AND SENIOR MEDICAL STUDENTS AT THE UNIVERSITY OF IOWA

	Junior	Senior
Questionnaires sent	148	129
Questionnaires returned	147	127
Reaction to Tine test in the sophomore medical year		
Positive reactions	14	9
Negative reactions	133	118
Percentage of sophomore reactors	9.5%	7.1%
Reaction to PPD in junior and senior medical year		
Tuberculin negative students entering junior year	133	118
Number retested with PPD	113	103
Number of convertors	8	9
Percentage of total retesting	7.1%	8.7%
Number of times tested (Avg.)		
Intermediate PPD	1.9	1.9
Second strength PPD	6(6x)	11(14x)
Length of time since last test in months	3.6	6.2
Convertors receiving INH	6	5
Convertors who had a chest film	7	6
Convertors with documented exposure to active tuberculosis	4	2

One hundred and forty-seven questionnaires sent to the 1971 junior class were returned. Fourteen members (9.5%) were either positive to the Tine test given in the sophomore year or were known reactors and did not take the test. Of the 133 non-reactors in the sophomore year, 113 retested themselves during the junior year on one or more occasions. Intermediate strength PPD was applied an average of 1.9 times per person during the junior year. Six individuals applied a second strength PPD on one occasion. An average of 3.6 months have elapsed since last test was given. Eight of these 113 junior students converted to a positive reaction to intermediate strength PPD. Hence 7.1% of junior students converted to a positive PPD during their first year of clinical experience. Four of the seven convertors admit contact with a patient with documented active tuberculosis. Seven had a chest x-ray and six are receiving prophylactic INH.

DISCUSSION

The results of this study indicate that 7.1% of the 1971 junior class and 8.7% of the 1971 senior class of medical students at The University of Iowa converted to a positive reaction to intermediate strength PPD during their clinical years. As one might expect, the data indicate a positive correlation between exposure to clinical medicine and the rate of tuberculin conversion. It was anticipated that a larger percentage of the senior class would have converted, approaching a rate two times that seen in the junior class. The reason for this discrepancy is not known but may relate to the fact that the average interval since the last PPD was applied was 3.6 months in the junior class, but was 6.2 months in the senior class. Many of the seniors had not tested since their junior year. If more of the seniors had current information regarding their tuberculin status, a larger percentage of convertors may have been found.

The results of this study are somewhat alarming. A tuberculin conversion rate of 7.1% for one year of clinical exposure and 8.2% for two certainly is an indication that an occult reservoir of infection with tuberculosis may reside within the medical profession itself. It has been shown that approximately 2% of tuberculin convertors with negative chest films may have demonstrable mycobacteria in sputum samples in gastric washings.[2] It is possible that a much larger percentage have positive sputums for a brief period early in the course of their disease, but by the time they present clinically, it has been localized.[2] Also to be noted is that the exposure rate in institutions other than Iowa may be higher as Iowa had the lowest rate of active tuberculosis in the United States in 1970.[3] (Sixty-six new cases of active tuberculosis were diagnosed at The University of Iowa during that year.)

In addition to this hazard to the physician himself, the possibility of distributing the infection to those individuals whose primary disease imposes an increased susceptibility to the tubercle bacillus, e.g., diabetes, gastric resection, steroid administration, silicosis, etc., also deserves major consideration.[4, 5] Therefore it seems apparent that doctors, nurses, custodial and nutritional staff should be skin tested yearly and placed on prophylactic isoniazid 300 mg daily for one year should a conversion occur.[4] It has been shown that this regimen will reduce the chance of developing active tuberculosis by 61 times.[6] The use of BCG is an alternative. The Ad Hoc Committee of Tuber-

culin Control through the Commission on Acute Respiratory Diseases of the Armed Forces Epidemiology Board has reviewed the question of INH vs. BCG in returning Viet Nam veterans. They recommend the use of BCG when the tuberculin conversion rate reaches 5% per annum. Prophylactic INH would suffice with tuberculin conversion less than 5%.[7] It is apparent that further investigation is mandatory, that the problem be characterized on a larger scale to include all hospital personnel from a variety of geographic areas, and that the relative advantages of all modes of therapy be assessed.

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OCTOBER—IMMUNIZATION ACTION MONTH

Alarmed by steadily falling polio immunization levels, the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics and the Center for Disease Control have declared October, 1973, "IMMUNIZATION ACTION MONTH." This is the "kick-off" to a nationwide campaign to improve immunization of preschool children.

Table I shows the proportion of American children aged one to four years considered adequately vaccinated against specified diseases by annual National Immunization Surveys. In addition to demonstrating a general decline in children receiving adequate polio immunization over the decade, the Table indicates some 25-40% of preschool children nationally lack at least one dose of other vaccines. In Iowa, recent immunization surveys of two-year-old children show somewhat better coverage rates for all of these vaccines, but one can still estimate as many as 48,000 Iowa preschool children need one or more additional doses of polio, 13,000 need DPT, 28,000 need measles, and 47,000 need rubella vaccines. Mumps vaccine coverage is even lower than that for the other "routine" vaccines.

TABLE I

PERCENT OF POPULATION 1-4 YEARS OF AGE WITH SPECIFIED DOSES POLIO, DPT, MEASLES, AND RUBELLA VACCINES U.S.A., 1963-1972

Year	Polio 3+OPV/ 3+IPV	DTP 3+ Doses	Measles 1 Dose	Rubella 1 Dose
1963	84.1	72.9	na	na
1964	87.6	76.0	24.0	na
1965	73.9	73.9	33.2	na
1966	78.9	74.5	45.5	na
1967	70.9	77.9	56.4	na
1968	68.3	76.5	58.8	na
1969	67.7	77.4	61.4	na
1970	65.9	76.1	57.2	37.2
1971	67.3	78.7	61.0	51.2
1972	62.9	75.6	62.2	56.9

The first phase of "Immunization Action Month" will be an intense public health education effort to involve prominent national and state level medical leaders, politicians and celebrities. Iowa Governor Robert Ray will issue a formal "Immunization Action Month" proclamation.

The second phase of "Immunization Action Month" consists of an "immunization audit" to encourage private physicians and public clinics to identify children on their patient rosters who need additional immunizations, then to actively encourage the parents to bring them in for the needed vaccines. This effort should complement programs already underway in Iowa to "audit" and adequately immunize children already enrolled in schools.

As part of its ongoing encouragement of immunization activities, the Iowa State Department of Health will provide practicing physicians with advice and assistance in immunization programming and evaluation and will supply DPT, polio, measles and rubella vaccines. Inquiries should be directed to Mr. Jim Thompson, Director, Immunization Section, Iowa State Department of Health, 515-281-3478.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

SHOULD THE TRUTH BE TOLD?

No, this is not to be a comment on Watergate; it is rather a comment on the right of the patient to know the truth. The June 1973 issue of PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE* presents a discussion on this subject. Lord Justice Edmund Davies asks if the doctor is under any legal duty to tell his patient the truth about his condition. Apart from special circumstances it is concluded that the law does not recognize any obligation by the doctor to tell the truth. However, if the patient can prove that damages flowed from the failure to have the truth given him the doctor may be liable. Thus, if the patient is damaged because he was not given the opportunity to "have his house in order" because the truth was withheld he may have cause for legal action.

The medical advisor will take all proper steps to learn for himself what the truth is about his patient. He, at least, must do this whether or not he then proceeds to impart it to the patient. Failure on the part of the physician to seek the truth is morally wrong and renders him legally liable for any harm which befalls the patient as a result. Basically, when the patient's condition is diagnosed he is to be told three things: (1) what is wrong with him, (2) what it may possibly mean in the future, and (3) what medical science has to offer him.

The Right Reverend Dr. J. A. T. Robinson of Trinity College, Cambridge, points out that all patients have a double attitude toward the doctor. First, there is an enormous respect and trust, and second, a niggling suspicion that doctors engage in some sort of conspiracy to withhold the truth, or at any rate, treat the patient as one who cannot be expected to understand. This is so common in a simple way—not informing the patient what his temperature may be, or what his blood pressure is. Such evasion may certainly arouse suspicion; it does not necessarily hold that "what he doesn't know won't hurt him."

Dr. Colin M. Parkes from the Travistock Institute for Human Relations, London, insists it is his responsibility to ensure that knowledge of dreadful import is communicated in a manner which will do as little harm as possible to the patient and his family. He feels the question is not "Should the doctor tell?" but "How shall the doctor tell and when?" He refers to the difference his studies have shown in the reaction to bereavement of those who had adequate warning and those who had little advance warning. The men and women with little or no advance warning were more depressed and less able to cope with the change in their life style. Dr. Parkes also emphasizes another important facet of truth telling—doctors must be most careful about making predictions about survival. Sometimes truth is stranger than fiction and the patient may be delighted 10 years later in relating he had been given "only 6 months to live."

The doctor must do no harm. He must fit his actions to his words. The doctor must work with and for the patient, and in conscientiously doing so not fear the law nor his own conscience whatever be the truth told or withheld. —M.E.A.

* Davies, Edmund, Robinson, J. A., and Parkes, Colin M.: Patient's Right to Know Truth. Pro. Roy. Soc. Med., 66:533-538, June, 1973.

ON BEING TRIMMED

Federal regulations effective July 1, 1973, require the periodic screening, diagnosis and treatment of children be extended to all persons under 21 years of age in "aid to dependent children" families. In fact, county welfare departments will refer these patients for screening. Any physician who cares for patients under Title XIX Medical Assistance is familiar with the screening invoice which must be completed to receive payment for services rendered. There are many questions and a concluding statement which reads, "I further certify that the service or supplies billed for were provided and the amounts shown are not more than my *usual and customary charge. . . .*"

Such information as body measurements, developmental assessments, vision acuity, hearing ability and unclothed physical examination is sought. Also, note must be made of any need for further consultation or follow-up, plus a summary of immunization status, and an itemization of services rendered.

When this examination is for a child entering his first year of school it becomes a very important physical and mental evaluation to say the least. A comprehensive evaluation must be made, the examination must be complete, the ability to hear and see properly must be determined, developmental and coordination skills are to be ascertained. It constitutes a complete appraisal of the child's ability to cope with the educational processes and complexities. This examination can be time-consuming if done in a *sincere* and *honest* manner. In addition, immunizations may require completion or up-dating. If deficiencies are noted there may be the need to arrange for consultations or further studies.

After the examination varying degrees of discussion with the parents are necessary and in order. Then, the report for the school has to be completed (and some of these are far from simple). Finally, the screening invoice must be completed and submitted. There is hope for a reasonably prompt, complete payment. But, that's where the bite comes! In some instances payment may be delayed 3-4 months (with no 1½ percent per month interest after 30 days). Furthermore, the maximum payment allowed was recently cut to $7.50.

In Des Moines it cost $8-$10 to have a poodle bathed and trimmed—no reports, no billings, cash at the time of service. Those pampered canines thus are made more pleasing to their masters, and how proudly those little pets behave after their ordeal. How proud are you, doctor, after being "trimmed"? Do you strut about, raising your little feet high, and hold your head up with poodle-like aloofness? After several of those screening ordeals per day I sometimes feel beat.—M.E.A.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Oct. 3	What's New in Stroke?
Oct. 4-6	Orthopedic Alumni Meeting
Oct. 4-6	Atherosclerosis Center Warkshop on Endothelium
Oct. 5-6	Dermatology for the Dermatologist
Oct. 11-13	Antibiotics and Infectian/Course in Infectious Disease
Oct. 19-20	Clinical Endacrinalogy: Emphasis on Thyroid
Oct. 23-25	Bia-Medical Ethics
Oct. 26	Iawa-Illinois Academies af Ophthalmalagy and Otalaryngalagy
Oct. 26-27	Salt, Water and Bload Pressure: "Much Ado Abaut Samething"
Oct. 31-Nov. 2	Cancer Teaching Days
Nav. 15-17	International Symposium on Eye and Systemic Disease
Nav. 28-29	Postgraduate Conference on Obstetrics and Gynecology

The Question Box



by WAYNE L. SEVERSON, M.D.

Dr. Severson is medical officer at Blue Cross and Blue Shield of Iowa. He was in private practice in Slater before assuming this administrative post several years ago.

How would you describe your responsibilities?

My primary responsibility as a medical consultant is to insure proper adjudication of claims requiring medical opinion. This responsibility also includes assuring the services conform with contract liability of Blue Cross and Blue Shield. In addition, medical judgment is provided to assure compliance with the rules and regulations promulgated by the government in Title XVIII and XIX programs. The cases adjudicated may involve subjects as varied as ambulance services, prosthetic devices, home health care, as well as medical review of underwriting applications. However, the majority of claims involve hospital and physician services.

Although I now occupy an administrative position, my 20 years of private practice leaves me with continued concern for patient care. And, of course, I am interested in and responsible for assuring fair and equitable treatment of the physician.

Are the questions you receive regarding claims similar or widely divergent?

Questions are widely divergent because of the multitude of services allowed in the various programs administered by Blue Cross and Blue Shield. These may originate within the company or come from physicians or others who request assistance and reviews of claims in question. The most prevalent questions involve the unusual or complicated medical or surgical claims. We also receive requests to review services and fee allowances, particularly those which pertain to our UCR Contract, or Medicare and Medicaid.

Improvement in claims handling is an obvious ongoing objective. Are the procedures, particularly the mechanisms for resolving questions, working reasonably well?

It is obvious that no one person can resolve all of the questions which are presented. We have a staff of physicians and nurses who are involved in evaluation of exceptional claims. Questions are most usually resolved by our staff after communications with the physicians.

We have established a close working relationship with the Iowa Foundation for Medical Care and rely on its expertise when problems cannot be resolved internally. This mechanism seems to be working rather smoothly. It offers a great opportunity for involvement by the practicing physician in the evaluation of medical care.

What suggestions would you offer to Iowa physicians to help them and you in the processing of claims?

The first and most important suggestion to ease the burden of submission of insurance claims is to employ an interested and capable insurance clerk. Her capabilities and expertise can be enhanced through attendance at medical assistants' workshops sponsored by Blue Shield.

Secondly, claim forms should be completed with particular emphasis on full identification of the services performed. Submission of additional information, e.g., operative report, discharge summary, etc., for those cases which involve unusual or extenuating circumstances, is of great value to us; it increases our efficiency and obviates the need for follow-up inquiries. We, of course, always stand ready to assist in any problems that may be present in the submission of Blue Shield claims.

IOWA HEALTH COUNCIL CONFERENCE THIS MONTH

What's the Iowa Health Council?

It's a conglomerate, obviously not in the manner of today's massive and multi-faceted business enterprises, but rather as an assembly of those separate organizations whose members deliver that important commodity—health care—to the state's citizenry.

The Iowa Health Council has nine member organizations each with a different but vital part to play in the delivery of health care in Iowa. The number of Council members (membership is by association or group, individuals do not hold membership) has increased by four since the organization was formed 37 years ago. The founding occurred in 1936 with five charter organizations: the Iowa Medical Society, the Iowa Dental Association, the Iowa Pharmaceutical Association, the Iowa Veterinary Medical Association and the Iowa Nurses' Association.

Iowa Interprofessional Association was the organization's initial name. This gave way in 1967 to the present more descriptive designation. Over the span of years four additional organizations have had their petitions for membership accepted: the Iowa Hospital Association, the Iowa Society of Osteopathic Physicians and Surgeons, the Health Facilities Association of Iowa and the Iowa Podiatry Society.

The stated purpose of the IHC is not elaborate but it sets forth clearly and simply the organization's reason for being: *To provide a forum and a mechanism for member organizations, representing providers of health care in the State of Iowa, to advance the art, science, distribution and delivery of health care in Iowa.*

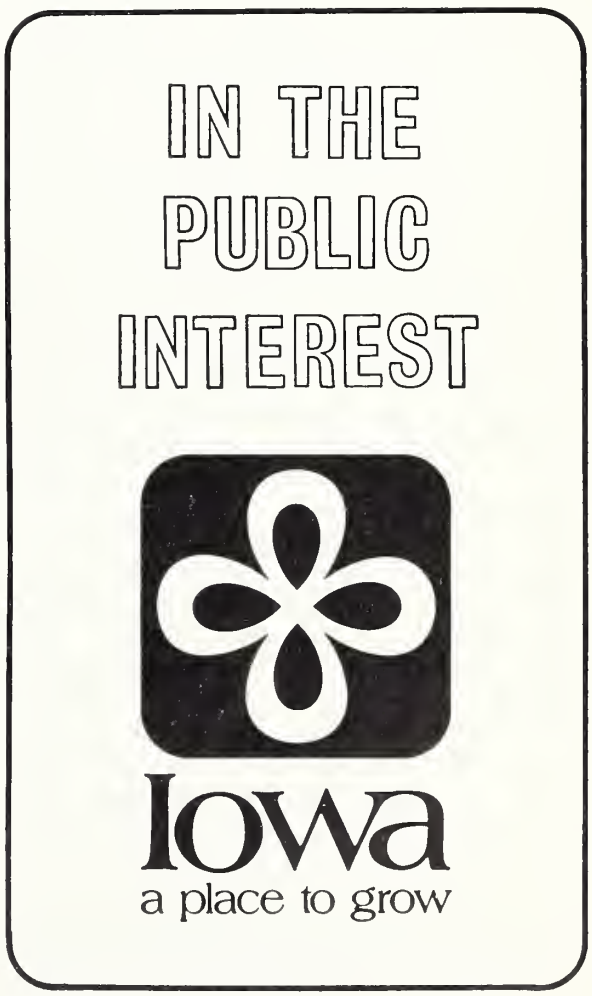
What does the Iowa Health Council do?

Its most conspicuous activity has been an annual educational program of one type or another. These informational sessions have been conducted sometimes for the general public, sometimes for a special segment of the public and sometimes just for IHC members. Two conferences (in 1969 and 1970), for example, provided youth from across the state (plus educators, clergy, social workers, etc.) with insights on drug use and abuse. Approximately 4,000 persons attended these two day-long meetings in Des Moines.

In 1971 a specially selected group of 300 students and teachers participated in a conference devoted to special teenage problems. In this, and in each of the other programs, the reaction of those attending has been most favorable.

In an earlier year, an informative conference on medical quackery was presented in Des Moines for approximately 200 professional, business and civic leaders. Those attending were informed regarding patent medicine quackery, nutritional quackery, device quackery, cancer and arthritis cures and treatments, etc.

Upcoming this month is the Health Council's 1974 educational program. This year's program is essentially intramural in nature and is de-



scribed as a Leadership Conference for officers and interested members of the participating organizations.

Topics to be considered and the speakers for the October 17 Leadership Conference in Des Moines are as follows:

Solving the Health Manpower Problem—Israel Light, Ed.D., Chicago, Dean, University Health Services, Chicago Medical School, and Paul Seebohm, M.D., Iowa City, Associate Dean, College of Medicine, University of Iowa.

Continuing Education Requirements for Health Professionals—Etta Rasmussen, R.N., Iowa City, Assistant Dean, College of Nursing, University of Iowa.

Consumer Representation on Professional Licensing Boards—Roger Anderson, D.O., Davenport, Member, Iowa State Board of Medical Examiners.

Office of Comprehensive Health Planning & Health Facilities Review—Joyce Montag, Creston, Chairman, Health Facilities Review Committee, Advisory Council, OCHP.

Chiropractic and Public Law 92-603—Thomas H. Ballantine, Jr., M.D., Boston, Chairman, Committee on Quackery, American Medical Association.

Professional Standards Review Organization (PSRO): The Role of the Private Sector—George W. Wells, Chicago, Associate Director, Health Insurance Council, and John H. Sunderbruch, M.D., Davenport, President, Iowa Foundation for Medical Care.

This will be the second year in which the Council has presented a conference with the objective being to inform and inspire those within its own ranks. Theme of the 1972 meeting was "Sharing a Common Goal . . . Serving the Consumer."

At its recent annual meeting the Board of Directors of the Iowa Health Council acted to continue this educational programming and additionally authorized a continuation of the long custom of hosting the members of the Iowa General Assembly and other state officials at a legislative dinner.

This event is presented to demonstrate the interest of the IHC member organizations in the lawmaking process and to direct attention to the important area of health care.

Iowa Health Council officers for the coming year were selected at the September annual meeting: Elizabeth Hammes, R.N., Des Moines, Iowa Nurses' Association, president; Myron Bos, D.O., Albia, Iowa Society of Osteopathic Physicians and Surgeons, president-elect; Paul Johns, D.P.M., Des Moines, Iowa Podiatry Society, vice-president; and Donald Taylor, Des Moines, Iowa Medical Society, secretary-treasurer.

The efforts of many fine organizations go largely unheralded. From time to time it is appropriate to acknowledge their various and productive programs. We salute the Iowa Health Council at this time.

The Board of Directors of the Iowa Health Council are chosen by the member organizations and are listed below.

IOWA HEALTH COUNCIL
BOARD OF DIRECTORS

IOWA DENTAL ASSOCIATION

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F. D. Wertman, D.V.M., Des Moines

State Department of Health

DISTRIBUTION POLICY FOR IMMUNIZING BIOLOGICALS, SERA AND ANTIBIOTICS

The Iowa State Department of Health maintains selected immunizing biologicals and certain drugs for intrastate distribution. These materials are provided to physicians as a service to the people of the state. Distribution is designed to encourage the immunization of children, to control infectious diseases, to provide a source of infrequently used items which local pharmacies may not stock and to provide antibiotics specifically for treatment of venereal disease. Another end of the distribution effort is to encourage reporting of cases of disease which otherwise might escape the Department's notice.

I. DISTRIBUTION:

To Private Physicians:

Most vaccines, without limit, are supplied without charge to private physicians for administration in their offices to persons under 19 years of age.

Public Clinics for Children:

Appropriate vaccines, without limit, are available without charge to Well Child Conferences, School Programs, Head Start Programs and other clinics which have been *approved* by a county medical society or its committee on immunization. Vaccines for clinics are furnished in large quantity vials on request of the person in charge of the clinic. Large quantity vials are *not* suitable for breakdown and redistribution by program directors if immunizations are to be administered in the offices of several physicians. Clinics receiving these vaccines are requested not to charge the patient for the vaccine, but may charge a fee to cover costs incidental to administration. A form, certifying that no charge is made *for the vaccine,* accompanies each shipment and must be returned to the address printed on the form.

Public Clinics for Adults:

Vaccines for these age groups will be supplied on a cost reimbursement basis. Vaccine for county-wide programs may be purchased through the Department.

Shipment of Vaccine:

Except for gamma globulin, which is not damaged by unrefrigerated shipment, and emergency shipments of rabies vaccine, biologicals *will not be dispatched from the State Department of Health between Thursday noon and Monday morning because of delays in transport. NO* order will be accepted for less than *100 doses* of oral polio vaccine. This product must be shipped packed with dry ice and transportation charges are prohibitive on smaller orders. *Large orders for biologicals to be used in school or area programs should be placed at least two weeks in advance in order to permit sufficient time for procurement and proper handling.*

II. EMERGENCIES OR UNUSUAL REQUESTS

1. In the event of an emergency which requires immediate information or shipment of any of the biologics, sera or antibiotics routinely supplied or other biologics not routinely supplied, the Department will assist in acquisition and delivery for any physician in the state. Physicians may obtain assistance by calling:

Weekdays between 8 a.m. and 4:30 p.m. **Area Code 515/281-3478**

Evenings and Holidays:

Dr. Stanley Hendricks—515/279-4231

or

Dr. Charles Herron—515/277-4393

or

Mr. Jim L. Thompson—515/278-2610

or

Mrs. Clara Whetstone—515/262-3711

2. *Snake Anti-Venin:*

Polyvalent anticrotalid: Amount according to weight of patient. For treatment of bites of most American snakes. It is of equine origin. It may be obtained direct from the Department on an emergency basis.

3. *Vaccinia Immune Globulin (VIG):*

This material, formerly handled by the American National Red Cross, is now distributed by the National Center for Disease Control. Any physician who believes VIG might be required for a patient should telephone the Commissioner of Public Health, whose name, address and telephone number appear below. If it is agreed the condition of the patient will benefit from treatment with VIG, the Commissioner will arrange for shipment. The Center for Disease Control has 24 hour coverage and is equipped to arrange immediate transportation to the attending physician by the most rapid means available. The Department will assist receipt and delivery.

For assistance in obtaining VIG, call:

Mr. Norman L. Pawlewski

Acting Commissioner of Public Health

Iowa State Department of Health

Between 8 a.m.-4:30 p.m.—**515/281-5605**

After 5 p.m.—**515/287-1291**

III. IMMUNIZING AGENTS AVAILABLE—INFECTIOUS DISEASES:

1. *Diphtheria Antitoxin:*

For treatment of clinical cases. Product is of equine origin. Available in vials of 10,000 and 20,000 units. Request amount in accordance with weight of patient.

2. *Tetanus and Diphtheria Toxoids Combined (aluminum phosphate absorbed) for Adult Use (TD):*

Available in 5 cc vials—10 doses.

3. *Diphtheria and Tetanus Toxoids and Pertussis Vaccine Combined (DTP):*

Available in 7.5 cc vials—15 doses.

4. *Measles Virus Vaccine:*

Available in single dose vials, needle and syringe included. Available in 50 dose vials for community-wide programs for administration by jet injectors only.

A. Live, Attenuated—Schwarz Strain (Lirugen)

B. Live, Attenuated—More Attenuated Enders' (Attenuvax)

5. *Poliomyelitis Vaccine, Live, Oral, Trivalent (Sabin):*

Available in one dose and 10 dose vials. For oral administration.

6. *Rabies Vaccine (Duck Embryo):*

For active immunization following bite of rabid or suspected rabid animals. May be used for pre-exposure immunization of persons at high risk, e.g. veterinarians, animal handlers, dog catchers, etc.

Anti-Rabies Hyperimmune Serum:

For use in passive immunization of persons bitten about the face and neck or with multiple or deep bites by rabid animals. It does not replace anti-rabies vaccine but serves as an adjunct in certain situations. Product is a serum of equine origin.

7. *Rubella Virus Vaccine, Live:*

Available in single dose vials, needles and syringe included.

A. Strain HPV 77 prepared in duck embryo (Meruvax)

B. Strain Cendehill prepared in rabbit kidney cell (Cendevax)

8. *Measles and Rubella Virus Vaccine, Live (Combined Vaccine):*

Enders attenuated Edmonston Strain (Measles) and Strain HPV-77 (Rubella). Available in single dose vials. Available in 50 dose vials for community-wide programs for administration by jet injectors only.

9. *Smallpox Vaccine (Dryvax):*

Available in 25 dose vials only. Restricted to use for international travelers, medical personnel or importation control.

The Iowa State Department of Health provides most vaccines to private physicians without charge for administration to persons 19 years of age and under. Vaccines for clinics are furnished in large quantity vials on request.

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10. *Typhoid Vaccine:*

Available in 1½ cc vials. For persons in close contact with a known case of typhoid fever or a known typhoid carrier.

Not furnished for wide spread use in "disaster conditions."

In some circumstances (as in the case of military personnel, missionaries, etc.) biologics for immunization against cholera and/or plague may be obtained from the Department if they cannot be obtained locally by the physician.

IV. THERAPEUTIC AND PROPHYLACTIC BIOLOGICALS AND DRUGS:

1. *Immune Serum Globulin:*

(ISG) Available in 2 cc vials. For indigent or medical hardship patients who are considered to have been definitely exposed to known cases of infectious hepatitis, measles or german measles. For patients able to pay, cost reimbursements will be billed to physicians. More detailed policy statement on Immune Serum Globulin distribution is available upon request.

2. *Anti-Tuberculosis Drugs:*

(Supplied upon written request from a private physician.)

Primary:

Isoniazid (INH) tablets or Isoniazid (INH) Nydrazid Syrup. For anti-tuberculosis therapy or chemoprophylaxis of recent tuberculin converters and other positive reactors of high risk.

Para-Aminosalicylic Acid (PAS) or Para-Aminosalicylic Acid (PAS-C) Pascorbic—For tuberculosis therapy only.

Streptomycin (SM)—For tuberculosis therapy only.

Secondary:

Ethambutol (Myambutol)—For tuberculosis therapy only.

Pyrazinamide (Pyrazinamide)—For tuberculosis therapy only.

Supplement:

Pyridoxine (Vitamin B6)—Used in conjunction with INH regimen.

3. *Antibiotics—Venereal Disease Control:*

The following drugs are available without cost to physicians for the treatment of reported cases of venereal disease. Requests for drugs should be made directly to the Division of Venereal Disease Control and must be accompanied by case report.

Penicillin G, Procaine, Aqueous (4 cc syringes, 600,000 u/cc):

4,800,000 units for male and female gonorrhea cases, with probenecid, 1 gram.

4,800,000 units to 12,000,000 units for syphilis cases, depending upon diagnosis.

Aqueous penicillin is the drug of choice in the treatment of gonorrhea.

Ampicillin (500 mg capsules):

3.5 gm for male and female gonorrhea cases, with probenecid, 1 gm.

Tetracycline (500 mg capsules):

Distribution limited to use for treatment of those syphilis and gonorrhea cases in which penicillin sensitivity has definitely been established or in cases known to be due to penicillin resistant organisms.

Spectinomycin (Injectable):

2 gm vials for male gonorrhea cases.

4 gm vials for female gonorrhea cases.

Distribution limited to use for treatment of those gonorrhea cases in which penicillin sensitivity has been definitely established or in cases known to be due to pencillin resistant organisms.

Probenecid (500 mg tablets):

New recommendations for treatment of gonorrhea advise the administration of 1 gm of oral probenecid preferably given at least 30 minutes prior to use of Aqueous Procaine Penicillin G, or Ampicillin. Probenecid is used as an adjunct to penicillin therapy because it reduces the rate of renal tubular excretion of penicillin thereby prolonging the plasma concentration.

Penicillin G, Benzathine (4 cc syringes, 600,000 u/cc):

Distribution restricted to use for treatment of syphilis cases—2,400,000 to 9,000,000 units depending upon diagnosis. Benzathine Penicillin G is the drug of choice for the treatment of syphilis.

Erythromycin (250 mg tablets):

Distribution limited to use as an alternate when tetracycline therapy is contraindicated due to possible tooth discoloration.

Pathology Capsules

NITROBLUE TETRAZOLIUM (NBT) TEST

The differentiation of bacterial and viral infection has posed a diagnostic dilemma since the discovery of effective antibiotic agents: to treat or not to treat? Attempts at culture of the offending microorganism are relatively expensive, slow in providing information, fraught with technical difficulty in some cases, and pose problems of interpretation in others. A simple, *in vitro* test[1] was devised by Park *et al* in 1968, which indirectly determines the percentage of phagocytically active neutrophilic leukocytes in the venous blood. Since bacteria are actively phagocytosed by neutrophils in the presence of an intact immune system, whereas viruses are not,[2] assay of neutrophil phagocytosis may serve as an effective method of differentiating viral from bacterial infection.

The test is simple to perform, being within the capability of most hospital laboratories and many physicians' office laboratories:[3] venous blood is drawn into a heparinized tube, an aliquot incubated with buffered nitroblue tetrazolium (NBT), and the mixture smeared on a microscope slide and stained with Wright's stain. The percentage of neutrophilic leukocytes having intracellular blue-black crystals is determined by counting 100 neutrophils. Increased sensitivity is obtained by calculating the number of positive cells per cubic millimeter by derivation from the product of leukocyte count, per cent neutrophils in a conventional differential count, and the per cent of NBT-positive neutrophils. Values seen in normal subjects and in patients with uncomplicated viral infections are less than 11 per cent positive neutrophils and less than 1,100 positive neutrophils per cubic millimeter, whereas patients with bacterial or fungal infections will have scores elevated above this range.

A brief review of the mechanisms involved in the NBT test reveals potential limitations and an additional important use for this procedure. Unstimulated leukocytes migrate to the site of infection, phagocytose bacteria, and a variable number of these re-enter the bloodstream and become available for sampling in the venous blood. Phagocytosis results in activation of the hexose monophosphate pathway (HMP) with production of increased amounts of reduced nicotine adenine dinucleotide phosphate (NADPH). NBT is presented to the leukocytes *in vitro* in its oxidized form, a yellow soluble compound. The NADPH reduces the NBT within the leukocyte, converting it to a blue-black insoluble crystalline precipitate in the cytoplasm of the leukocyte.

If the phagocytic leukocytes are unable to regain entry into the circulating blood, as in the case of an abscess, early localized infection,[4] or bacterial meningitis,[5] a "normal" score will be obtained. Selective sampling of specific body fluids may provide increased sensitivity, however. Leukocytes from the cerebrospinal fluid of patients with bacterial meningitis were found to be consistently and strongly NBT "positive,"[5] explainable on the basis of a localized infectious process with poor return of the leukocytes to the circulation in the early phase

This discussion has been prepared by the Department of Pathology at Mercy Hospital, Des Moines, Iowa. The authors are Harrison Pratt, D.O., a resident in Pathology, and Joseph Song, M.D., head of the department. The references noted may be obtained from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

of the disease. An attempt at differentiating inflamed and noninflamed appendices has been disappointing, probably due to the localized nature and noninfectious pathogenesis of the process.[6] Deficiencies of the immune system may also produce normal NBT results in the face of bacterial infection: oral steroid therapy,[7] hypogammaglobulinemia, hypocomplementemia, and chronic myelogenous leukemia in relapse,[4, 7] SLE,[9, 10] and lymphoma.[11]

False positive scores have been reported in pregnancy[6] and in patients on oral contraceptives,[12, 13] in myelofibrosis,[4] and in viral meningitis,[15] acute viral hepatitis,[14] and osteogenesis imperfecta.[8] The exact significance of these data is not clear, although it must be noted that not all of the patients with these conditions displayed increased NBT reduction. A constantly found elevation of NBT reduction occurs in newborn infants for the first two weeks post partum, after which normal reactivity is observed.[16] This phenomenon may relate in some way to the occasional elevation of NBT reduction seen in apparently normal pregnancies.[6]

An additional use of the NBT test is for the confirmation of the diagnosis of chronic granulomatous disease (CGD), a childhood disease characterized by failure of intracellular killing

(Please turn to next page)

Morbidity Report for August, 1973

Disease	June 1973	1973 to Date	1972 to Date	Most August Cases Reported From These Counties
Amebiasis	39	54		Dallas, Davis, Washington
Chickenpox	14	10781	6450	Scattered
Conjunctivitis	10	810	643	Scattered
Encephalitis, type unspecified	2	11	2	Iowa, Johnson
Enterobiasis	1	2		Scott
Enteropathogenic E. coli	2	6		Dubuque, Polk
Erysipelas	1	3		Crawford
Gastrointestinal viral infection	47	5325	4274	Scattered
Giardiasis	3	13		Franklin, Iowa, Johnson
Guillan-Barre Syndrome	1	4		Black Hawk
Hand, foot, and mouth	2	2		Johnson, Muscatine
Hepatitis, infectious	15	160	203	Scattered
Hepatitis, serum	5	31	43	Linn, Polk, Warren
Hepatitis, type unspecified	5	14		Iowa, Polk, Pottawattamie, Woodbury
Herpangina	1	1		Johnson
Herpes simplex	5	43		Clinton, Johnson, Jones, Polk
Herpes zoster	3	12		Jasper, Johnson, Washington
Histoplasmosis	2	8	20	Henry, Johnson
Impetigo	5	210	227	Clay, Linn
Infectious Mononucleosis	14	476	594	Scattered
Influenza-like illness	2	11385		Johnson
Lymphogranuloma venereum	1	2		Polk
Malaria, imported P. vivax	1	1		Polk
Meningitis, Meningococcal	2	18		Muscatine, Polk
Meningitis, pneumococcal	1	3		Clinton
Meningitis, viral	4	9	4	Des Moines, Palo Alto
Meningitis, type unspecified	3	16	14	Black Hawk, Scott, Woodbury
Mumps	8	3010	5667	Scattered
Pinworms	1	6		Dallas
Pneumonia	61	775	599	Scattered
Rabies in Animals	12	164	274	Scattered
Rheumatic Fever	1	15		Linn
Rocky Mountain Spotted Fever	1	7	2	Johnson
Rubella	3	190	384	Dubuque, Polk, Tama
Rubeola	1	280	716	Polk
Salmonellosis	24	114	105	Scattered
Shigellosis	19	192	200	Scattered
Streptococcal infections	195	4745	4826	Scattered
Tuberculosis, active	9	89	76	Scattered
Tuberculosis, inactive	2	17		Buchanan, Poweshiek
Venereal Disease				
Gonorrhea	710	4058	4062	Scattered
Syphilis	40	274	337	Scattered

of bacteria by neutrophils, due to inadequate stimulation of HMP activity, resulting in increased susceptibility to infection.[17] Low NBT scores are obtained in CGD in the face of frank bacterial infection and are a reflection of aberrations in lysosome-phagocytic vacuole interaction.[3]

This simple procedure provides a valuable diagnostic tool in the evaluation of the patient with occult or poorly defined infection, providing rapid information of clinical value. Utilization of the NBT reduction test can reduce unnecessary antibiotic treatment and suggest the need for further clinical investigation. Like all laboratory data, the NBT scores need to be interpreted in the light of the clinical picture, bearing in mind the basic limitations of the test. It is a valuable parameter in the evaluation of the patient with suspected infectious disease, but it is not a panacea.

The procedure is primarily an assessment of neutrophilic leukocyte function, rather than a specific test to differentiate viral and bacterial infection,[18] and so the results obtained must be interpreted from that aspect.

THE PHYSICIAN AND HIS RELATIONSHIP TO SOCIETY

(Continued from page 470)

just been described. You must maintain a flexible approach so that adequate response to constant rapid change can be carried out. Our medical care has been so good that it has caused the community to desire it intensely. You must participate in making sure that the public expectations are consonant with the possibilities of the kind of care that can be given. You must devise the means to accept the challenges of altered distribution, the altered attitudinal set of the profession and increased costs, so that the ethical values of the profession are maintained and all of the people receive the excellent care which can be produced as a result of the educational and research activities of the profession. This can only be achieved by cooperative study and action of all segments of the health team and society itself. It will take much human understanding with plenty of give and take. To be successful it will require highly educated and flexible leadership from physicians and other health care personnel. You must become involved. As a beginning, the two organizations which will help you most are the organized medical societies and the Medical College and Hospital here. Make yourself a continuing part of these organizations and your communities.

PLEA TO LISTEN

I want to conclude with a story which takes us back to the beginning of this essay—our public image. It is a true story. I had the privilege of attending a luncheon at which Harry Schwartz, a senior editor of THE NEW YORK TIMES and author of the book, THE CASE FOR AMERICAN MEDICINE, related the following about his mother, a lady in her eighties. Mrs. Schwartz had had a bout of pneumonia and was treated by one of the leading internists in New York City. She had had gallbladder disease and had a cholecystectomy by one of the best surgeons in New York City. She had had trouble with her uterus and had a hysterectomy by one of the outstanding gynecologists of this country. She had had other bouts of illness treated by outstanding internists and the various specialists in the city of New York. Harry Schwartz once asked her, "Which one of these men do you go to for general medical advice?" She said, "None." "Who do you go to for medical advice?" She answered, "You, Harry." He said, "Why do you say this?" She answered, "You listen." So I close with this admonition—listen, listen to your patients, listen to your colleagues, listen to the public and demonstrate the fact that you *care* and are trying to understand. These were the enduring and endearing qualities of Stevenson's physician.

IOWA Specialty Groups

IOWA SOCIETY OF ANESTHESIOLOGISTS . . . New officers of the Society elected at recent annual meeting in Des Moines are Roger Westerlund, M.D., Ames, president; Charles N. Hull, M.D., Des Moines, president-elect; and Donald L. Sweem, M.D., Des Moines, secretary-treasurer.

IOWA ACADEMY OF FAMILY PHYSICIANS . . . The Academy held its silver anniversary Scientific Assembly and Annual Meeting September 12 and 13 in Des Moines. Scientific lecturers included George Crile, Jr., M.D., Cleveland, Ohio; Malcolm McCannel, M.D., Minneapolis, Minn., and Gordon Deckert, M.D., Oklahoma City, Okla. During 65th Iowa General Assembly, 98 members of the Iowa Academy served as "Doctor for the Day" at the Statehouse.

IOWA CHAPTER, AMERICAN COLLEGE OF SURGEONS . . . Topic of medical education will be considered by the Chapter at a December 1 meeting in Des Moines. Names of physicians in the various surgical disciplines within the several districts of the Iowa Foundation for Medical Care have been approved and submitted to the Foundation. These physicians are to act as peer review consultants.

IOWA CLINICAL SURGICAL SOCIETY . . . Spring meeting in Des Moines was hosted by John T. Bakody, M.D., Clifford Losh, M.D., Howard G. Ellis, M.D., H. Kirby Shiffler, M.D., and Dwight C. Wirtz, M.D. Speakers included Dr. Shiffler, Dr. Bakody, Sinesio Misol, M.D., Noble W. Irving, M.D., Donald Sweem, M.D., and Edward J. Drew, M.D. Merle J. Brown, M.D., Davenport, was installed as president.

IOWA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS . . . Fall meeting of the Chapter occurred September 19 and 20 in Iowa City in conjunction with the annual University of Iowa Postgraduate Course in Pediatrics. Guest speakers included Drs. Lewis Fraad, Dane Prugh and Eugene Ensminger.

IOWA PSYCHIATRIC SOCIETY . . . Fall meeting of the Society will be November 7 at the Des Moines Hyatt House. Geigy Pharmaceuticals will sponsor a symposium on that day with the Society and the Department of Psychiatry at The University of Iowa. This symposium will run from 10 a.m. to 5 p.m. and is open to all interested physicians and their wives. Topics include Medicine, Psychiatry and Social Change; Children of Divorce; Those Who Flunk the Tasks of Adolescence; Social Change and Psychological Problems in Middle Age, and Family Crises and Medical Practice.

CORONARY ARTERY SURGERY

(Continued from page 482)

patients. Five patients died and all were shown to have myocardial infarction which occurred prior to or during the period of operation. Four deaths occurred during 17 emergency operations—underscoring the importance of case selection so as to exclude operation in patients during an acute infarction. Only one patient died during 80 elective operations giving a 1.2% operative mortality for aorto-coronary bypass surgery in patients with chronic angina pectoris.

REFERENCES

The references noted in this article are available from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Doctor's Business

by LARRY E. LEAVERTON

ENHANCE PUBLIC RELATIONS WITH A PATIENT BROCHURE

A physician recently asked us to suggest a time-saving way of informing new and old patients about office policies, procedures and services. The doctors and medical assistants in this clinic were taking excessive amounts of time to explain routine matters regarding appointments, credit policies, emergency calls, etc.

A small neatly printed brochure was recommended. Any physician, in a group or solo practice, has office policies which often confuse patients. A written explanation not only benefits the patient, it promotes a better patient relationship and assists in a more smoothly run practice.

What should be included in such a brochure?

First, if it is a group practice, agreement to some uniform policy is necessary. If one doctor takes his own emergency calls while the others choose to alternate, or if the doctors disagree on basic policy, any attempt at written policy will only add to the confusion. A suggested outline could be as follows:

- Heading—name of group, listing of physicians and specialties, addresses and phone numbers.
- Introduction—statement of purpose and objectives. This could include a brief history of the group.
- Philosophy of medical practice.
- Office policies—office hours, explanation of emergency coverage, appointments, days office closed, credit and collection policy, billing, handling of phone calls, policy on prescriptions and refills, policy on referrals to other specialists.
- Sincere solicitation of questions, suggestions or criticisms on fees or services.
- Instructions for new patients, immunizations, obstetrical services, or instructions prior to complete physical examinations. (These could go on a separate insert sheet if too lengthy.)
- Hospitals used.
- Philosophy on house calls.
- What to do in after hours emergencies. Explanation of hospital emergency room services if available.
- Philosophy of medical fees—including an invitation to discuss fees where any question arises.
- Office policy in handling insurance and other third party coverage. Statement that insurance coverage is a contract between the patient and the insurance company. The policy may or may not cover the complete fee depending on the policy purchased. A statement dealing with Medicare and Medicaid is desirable. Whether or not assignments are accepted, assistance in answering questions should be volunteered.
- Many patients are confused about some of the medical specialties. If you are a specialist, additional information about your field is helpful. Some of the specialty boards and associations have such literature.

When the information is assembled it can be professionally printed or it can be a simple neatly typed one or two page flyer, duplicated by a letter service or printer. If the brochure is a first endeavor, the latter is preferable and easier to change and update.

The completed brochure can be mailed to all active patients and placed in the reception room. After the initial distribution it should be mailed or given to all new patients.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

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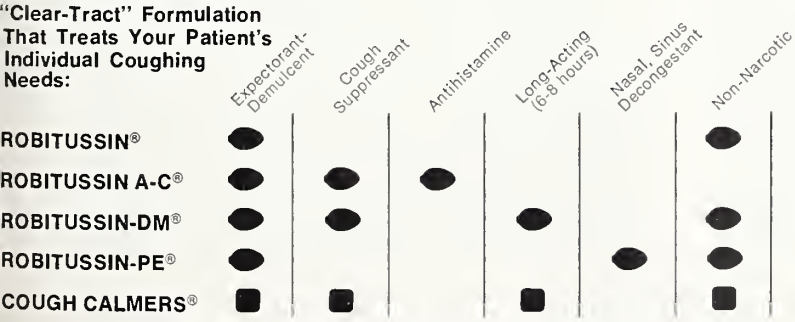
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About IOWA Physicians

Dr. Yang Ahan, formerly of Seoul, South Korea, has joined the Vinton Clinic. Dr. Ahan received his medical training in Korea and came to the United States in 1968. He served a year's internship in general surgery in Cedar Rapids and had a residency in surgery at U. of I. College of Medicine. . . . **Dr. C. P. Addison,** Waterloo, was recently elected chief of St. Francis Hospital medical staff. A medical staff member of St. Francis Hospital since 1952, Dr. Addison is president-elect of the Iowa Academy of Surgeons. **Dr. G. R. Clark,** Waterloo, was named St. Francis vice president; and **Dr. J. R. Moes,** Cedar Falls, secretary-treasurer. . . . **Dr. Scott K. Arnold,** pediatrician, and **Dr. John G. Brehm, Jr.,** internist, have joined Dubuque Medical Associates. Dr. Arnold is a 1967 graduate of University of Michigan Medical School and Dr. Brehm is a 1970 graduate of University of Pennsylvania Medical School.

A former Sioux City physician, **Dr. Arthur N. Sloan,** Los Angeles, California, celebrated his 100th birthday July 25. Dr. Sloan was a graduate of first four-year class at U. of I. College of Medicine in 1900. He practiced medicine in Leeds and Morningside before moving to California in 1938. . . . **Dr. R. B. Trimble,** internist, has joined the staff at Mason City Park Clinic. Dr. Trimble received the M.D. degree at Baylor Medical School, and completed his internship and residency at U. of I. College of Medicine and was a rheumatology fellow at University of Tennessee. . . . **Dr. Robert T. Brown** recently opened an office in Des Moines for the private practice of ear, nose and throat surgery, and facial plastic surgery. Dr. Brown received the M.D. degree at U. of I. College of Medicine in 1966. He interned at Parkland Memorial Hospital in Dallas, Texas and completed his residency in otolaryngology at University of Washington.

Dr. Beatriz Carlota-Orduna, Des Moines, has been named medical director of Central Iowa Health Services, Inc. Dr. Orduna is currently assistant director of Des Moines-Polk County Health Department. She will serve as consultant and adviser to the Central Iowa Health Services, Inc. staff. . . . **Drs. Chote** and **Bhoonsri Thumasathit,** natives of Thailand, will move soon from New York to practice family medicine in Hull. Dr. Chote Thumasathit is a radiologist and his wife is an internist. They are now practicing in Buffalo, New York. The husband-wife team was attracted to Iowa by a Thai doctor friend whose practice of medicine in eastern Iowa is progressing satisfactorily. . . . **Dr. and Mrs. John Jaquis** and four of their five children left Cedar Falls in July for a year at Memorial Christian Hospital in Bangladesh. The mission hospital was built in the early 1960's with donations from the Association of Baptists for World Evangelism. Mrs. Jaquis, a registered nurse, hopes to work in the hospital with Dr. Jaquis. . . . **Dr. David Paulsrud,** Sioux City, discussed fractures of the extremities at the quarterly meeting of the Tri-State Rescue and First Aid Association in Allen, Nebraska.

Dr. V. B. Mulay has returned to Dyersville and re-established his private practice of medicine and surgery. Dr. Mulay left Dyersville in 1971 to accept a position with U. S. Public Health Hospital in Norfolk, Virginia. . . . **Dr. Ralph R. Pray** has joined **Dr. Lawrence F. Staples** to practice internal medicine at Doctors' Park in Des Moines. Dr. Pray received the M.D. degree and completed his residency in internal medicine at U. of I. College of Medicine. Prior

to locating in Des Moines, Dr. Pray had been associated with King County Harborview Medical Center in Seattle, Washington. . . . **Dr. George Winokur,** professor and head of the U. of I. Department of Psychiatry, has won the $10,000 first prize for outstanding research awarded by the Anna-Monika Foundation of Basel, Switzerland. The works of 140 scientists were reviewed by the Foundation in determining this year's prize-winners. The Foundation supports studies on depressive illnesses. At the award ceremony, Dr. Winokur summarized his work on the division of the depressive syndrome into specific illnesses. . . . **Dr. J. H. Thomas,** Sibley, was one of the first doctors in the nation to volunteer for the new program, Project USA, which is sponsored cooperatively by AMA and U.S. government. Project USA was instigated by AMA to assist the National Health Service Corps in replacing physicians on vacation or attending postgraduate programs. Dr. Thomas was stationed at Immokalee, Florida, for 10 days treating migrant workers.

Dr. Eliza Pineda, Burlington, is named in 1974-1975 volume of WHO'S WHO IN AMERICAN WOMEN. Dr. Pineda is medical director of Henry and Louisa County Mental Health Center and a staff psychiatrist at the Des Moines County Mental Health Center. She received the M.D. degree at University of Santo Tomas, Manila, Philippines, and interned in Schenectady, New York. She had her psychiatric training in Traverse City, Michigan, and practiced at the Mental Health Institute in Mt. Pleasant. Dr. Pineda's husband, **Dr. Bernardo Pineda,** is director of Des Moines County Mental Health Center and has a private psychiatric practice in Burlington. . . . **Dr. J. S. Westly,** Mason City, has been elected president of the Iowa Clinical Society of Internal Medicine.

Dr. Amado G. Chanco has joined **Drs. George Tice** and **G. Travis Westly** in surgical practice at Independent Medical Surgical Group in Mason City. A native of Manila, Philippines, Dr. Chanco received the M.D. degree at Far Eastern University Institute of Medicine. He interned at Far Eastern University Hospital in Manila and Wilkes-Barre (Pa.) General Hospital. Following a two-year surgical residency at Riverside Methodist Hospital, Columbus, Ohio, Dr. Chanco practiced medicine in Linton, North Dakota. In 1970, he returned to U. of I. College of Medicine and completed his residency in surgery. . . . **Dr. Arnold M. Reeve,** former Iowa Commissioner of Health, has joined the Missouri Division of Health as Division 1 Chief at Cameron, Missouri, Dr. Reeve will administer the public health program for 12 counties. . . . **Dr. Agustina C. Jovez** recently joined **Dr. Margaret S. Emmons** in the practice of anesthesiology in Clinton. Dr. Jovez received the M.D. degree at Manila Central University College of Medicine in the Philippines. She served internships in Manila Central University Hospitals; and Misericordia General Hospital in Winnipeg, Manitoba, Canada, and completed residency in anesthesiology at U. of I. College of Medicine.

Dr. Harry A. Mahannah, Bloomfield, has been named acting medical director of South Central Mental Health Center. A graduate of U. of I. College of Medicine, Dr. Mahannah is a member of the Gilfillan Clinic. . . . **Dr. Patrick H. Kain** has joined **Drs. J. E. Murtaugh, E. C. O'Connor, James C. Carr** and **James R. Young** in the family practice of medicine at Medical Associates in New Hampton. A native of Algona, Dr. Kain received the M.D. degree at U. of I. College of Medicine and interned at Broadlawns Hospital in Des Moines. He recently completed his military service at Darnall Army Hospital, Fort Hood, Texas. . . . **Dr. Thomas Spragg,** Waterloo, has been named professional division chairman of Waterloo 1974 United Way Campaign. Dr. Spragg is past board member of Visiting Nurses Association and currently board member of Red Cross and Iowa Heart Association.

Dr. J. H. Gardner is new director of Student Health Service at Iowa State University. He succeeds Dr. Gail A. Proffitt who retired June 30 after 14 years as director. Dr. Gardner received the M.D. degree at U. of I. College of Medicine in 1957. He was clinical director of out-patient services at Woodward State Hospital, 1967-1969, a staff member of the ISU Student Health Service 1969-1972, and has been serving most recently in the emergency room at Iowa Methodist Hospital in Des Moines. . . . **Dr. James E. ten Broeke** has joined **Dr. J. C. Timmerman** in the private practice of dermatology in Iowa City. Dr. ten Broeke received

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the M.D. degree at Baylor College of Medicine in 1967. He completed his internship and residency at U. of I. Dr. ten Broeke will teach part time at University Hospital. . . . At recent annual meeting of Blue Shield of Iowa, **Dr. Larry W. Goetz,** Creston, was elected to three-year term on Blue Shield Board of Directors; **Dr. Clarkson L. Kelly, Jr.,** Charles City, was re-elected to his fourth term as member of Board.

Dr. David Kuper has joined **Dr. Jose Martinez** in Council Bluffs. Dr. Kuper received the M.D. degree in 1966 at University of Nebraska. He completed his internship and general surgery residency at Medical Center in Omaha and from 1968-1970 served the Navy in San Diego, California. Following military service, Dr. Kuper completed a residency in urology at University of Oklahoma. . . . **Dr. Lowell Bond** has returned from Nigeria to resume work at Family Practice Clinic in Ames. Dr. Bond was based at Sudan Interior Mission (SIM) Hospital in Jos, Nigeria. SIM is an inter-denominational Protestant organization engaged in evangelical and medical work in several African nations. Dr. Bond was accompanied by his wife and three children. Mrs. Bond served as a hospital nurse. Dr. Bond's presence enabled the two resident physicians at the hospital to take staggered leaves. He visited outlying dispensaries run by Nigerians trained at the mission and spent a month as the only doctor at the Galmi Hospital in Nigeria on the edge of the Sahara.

Dr. Yang Ahn has joined **Drs. D. C. Weideman** and **S. L. Anthony** in Vinton. Dr. Ahn attended medical school in Seoul, Korea, completed his internship in Cedar Rapids and served his residency in surgery at U. of I. College of Medicine. . . . **Dr. Robert R. Reick,** an internist, is new staff member at the Mental Health Institute in Independence. Dr. Reick received the M.D. degree at the University of Minnesota. Following a year at London College of Medicine studying nephrology, Dr. Reick interned at Los Angeles County Harbor General Hospital in Torrance, California, where he received the internship award for "Outstanding Performance in Gynecology." He served a residency in internal medicine at L. A. County Harbor General Hospital and from July, 1972, to the present time studied internal medicine at Mayo Graduate School of Medicine in Rochester, Minnesota.

DEATHS

Dr. C. M. Davis, 90, died July 27 in Centerville. Dr. Davis received the M.D. degree at Drake University in 1911 and practiced medicine at Exline for four years before moving to Centerville in 1915. He was appointed Examining Physician for the Local Board of Selective Service in 1940 and served in that capacity until this year. On March 20, 1973, Dr. Davis received a certificate of appreciation from the Iowa Headquarters of Selective Service and President Richard M. Nixon for his many years of service.

Dr. Stuart H. Cook, 72, of Rock Rapids, died August 3 at a Rock Rapids Hospital. Dr. Cook received the M.D. degree at University of Nebraska at Omaha in 1927 and interned at Allegheny General Hospital in Pittsburgh, Pa. Prior to locating in Rock Rapids, he practiced medicine with his father in Randolph. Dr. Cook served as secretary of Lyon County Medical Society from 1946 to 1969; was a past president of Rock Rapids Community School Board; 50-year member of Masonic Lodge; member of Lyon County Medical Society, Iowa Medical Society, and American Medical Association.

Dr. Julius Baron, 84, died July 22 at Rye, New York. Dr. Baron was former chief of radiology at Veterans Hospital and U. of I. College of Medicine faculty member. Born in Budapest, Hungary, Dr. Baron joined the staff at Veterans Hospital in Iowa City in 1956 and remained until his retirement in 1966.

Dr. John I. Marker, 84, of Davenport, died August 18 at Ridgecrest Retirement Village in Davenport. Dr. Marker received the M.D. degree at U. of I. College of Medicine in 1917. He had practiced psychiatry and internal medicine in Davenport since 1920. A veteran of World Wars I and II, Dr. Marker was a life member of American College of Physicians and American Psychiatric Association and member of Iowa Medical Society and American Medical Association.

Dr. Dean Finken, 41, of Logan, died August 18 of an apparent heart attack. Dr. Finken received the M.D. degree at U. of I. College of Medicine in 1962. Upon completion of his internship at Mercy Hospital in Cedar Rapids, he entered the private practice of Medicine in CR. He later became medical director at the Iowa Security Hospital in Anamosa, where he remained for two years, then returned to private practice in Cedar Rapids. Dr. Finken located in Logan in July, 1971. He was a past board member of Iowa Heart Association and had served in a number of other IHA positions. Active in a number of community and professional groups, Dr. Finken was a member of American Academy of Family Physicians; American Professional Practice Association, Health Planning Council of the Midlands, Chamber of Commerce, Kiwanis, Harrison County Medical Society, Iowa Medical Society and American Medical Association.

Dr. T. S. Walker, 92, of Riceville, died August 18 at Floyd County Memorial Hospital in Charles City. Dr. Walker received the M.D. degree at Rush Medical School and University of Chicago in 1906. Following his internship at Alexian Brothers Hospital in Chicago, he established his medical practice in Riceville where he remained until his retirement in 1957. He was a life member of Iowa Medical Society and American Medical Association. His son, **Dr. T. G. Walker,** is in family practice in Riceville.

Dr. J. H. Evans, 74, of Moline, Illinois, died August 27 at the Americana Nursing Home in Moline. Dr. Evans practiced medicine in Davenport from 1929 to 1950. A graduate of U. of I. College of Medicine, he entered the field of radiology in 1950 and completed his residency at University of Chicago where he also served on medical staff. He was a past president, treasurer and vice president of Scott County Medical Society, member of American College of Radiology, American Medical Association and former member of Iowa Medical Society.

Dr. H Dabney Kerr, 80, head of Department of Radiology at U. of I. College of Medicine from 1933 to 1955, died July 10 in Annapolis, Maryland. Dr. Kerr received the M.D. degree at Johns Hopkins in 1919. He left Iowa City in 1955 to become a consultant to Milton Campbell Radium Therapy Service at Memorial Hospital in Easton, Maryland and consultant to Radiology Department of Ann Arundel General Hospital in Annapolis, Maryland. Dr. Kerr served as executive secretary of American Board of Radiology from 1957 to 1968 and was past president of the Board. In recognition of his work, he recently received gold medals from the Radiological Society of North America and the American College of Radiology.

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Medical Assistants

by TENORA MEYER, CMA

NATIONAL CONVENTION IN WASHINGTON, D. C.

The 1973 National Convention of the American Association of Medical Assistants will occupy the week of October 21 and will take place in Washington, D. C. Highlights of the meeting include:

- A special program on emergency medicine on Thursday, October 25. This will be conducted by R. Adams Cowley, M.D., professor of thoracic and cardiovascular surgery at the University of Maryland. Dr. Cowley will describe the Maryland Institute for Emergency Medicine and its Center for Study of Shock Trauma.
- A panel discussion on "Current Health Care Legislation" to include Senator Peter Dominick (R., Colo.); Congressman William Roy, M.D. (D., Kan.); William R. Felts, M.D., chairman, D. C. Medical Society Legislative Committee; and C. W. Camalier, Jr., M.D., American Medical Association delegate from D. C. This will occur Friday, October 26.
- A White House tour for AAMA members on Tuesday, October 23. It is hoped Mrs. Nixon will be available to greet those on the tour.
- An evening at the John F. Kennedy Center for the Performing Arts on Tuesday, October 23. This will be a spectacular event in a magnificent structure.

A simulated CMA mini-test will be available to interested persons on Wednesday, October 24. The CMA dinner will occur the evening of October 24. A seminar for future CMA's is planned Friday, October 26. Also scheduled is a seminar for CMA's on October 21. A conference of state presidents and presidents-elect is planned on October 27.

Other events include a dinner honoring international visitors, a meeting of the House of Delegates, an education session on new developments in medical and medical assisting, and various tours. The tours will include Alexandria, Mount Vernon, Arlington Cemetery and the Naval Academy. Post-convention tours will depart Sunday, October 28, for Williamsburg, Virginia; Malaga, Spain, and Rome, Italy.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

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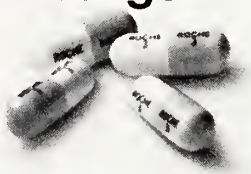
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depressants. As with all CNS-acting
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dependence have rarely been reporte
mended doses, use caution in admini
addiction-prone individuals or those
increase dosage; withdrawal symptor
convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
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To help you manage excessive psychic tension

President's Page



This is prepared as we await the 1973 "regular" session of the House of Delegates. The House has *continuing medical education* as one important subject on its docket. I note interestingly that 71% of the Iowa physician respondents to a recent CME survey expect shortly some sort of continuing education requirement.

The survey summary concludes: "If that expectation materializes, then the profession will face an increasing challenge to assure for itself high-quality educational experiences that respond to locally identified needs, plus a satisfactory method for accrediting or documenting each physician's attainment in a manner that will satisfy the profession and those outside it who are clamoring for the evidence of highest quality health care."

These words describe clearly and concisely the assignment before us.

In this vein, let me do some early drum beating for the 1974 IMS Annual Scientific Session. The Society's Program Committee is emphasizing the words "practical" and "something of value for everybody" in its planning for the April 18, 19 and 20 meeting in Iowa City.

I'll personally guarantee a topflight CME event.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

Second-class postage paid at Fulton, Missouri, and (for additional mailings) at Des Moines, Iowa. Published monthly by the Iowa Medical Society at 1201-5 Bluff Street, Fulton, Missouri 65251. Editorial Office: 1001 Grand, West Des Moines, Iowa 50265. Subscription Price: $5.00 Per Year.

IOWA Medical Miscellany

REGULAR MEETING HIGHLIGHTS . . . First "regular" session of the IMS House of Delegates occurred in Des Moines October 12-14. Highlights of the meeting were summarized in a mid-October IMS NEWS BULLETIN.

HOUSE STRUCTURE . . . Size of the policy-making House of Delegates will increase from approximately 145 to about 180 as a result of October action altering the ratio of delegates to physicians (active or life members) from 1:25 to 1:15 (or major fraction thereof). Allowance for one delegate per component society, regardless of number of physicians, was preserved. The present 12 councilor districts were retained as is.

DUES INCREASE . . . First dues increase in six years was authorized by the House of Delegates after much deliberate consideration. Dues will increase by $50 to $200 January 1, 1974. Inflation and desire to maintain a topflight organization were principal reasons behind the decision. A plea was sounded that expenses be curtailed wherever possible.

PAY TRIBUTE . . . The House paid tribute to Society Trustee Jerome F. Paulson, M.D., Mason City, who died September 20 while returning home from a meeting of the Board of Trustees.

TO FILL POST . . . John H. Kelley, M.D., Des Moines, was selected by the Board of Trustees October 12, to succeed Dr. Paulson as trustee. Dr. Kelley's appointment will carry until the 1974 annual meeting.

ARTICLE CHANGES . . . Prerequisite for holding IMS office was changed from five to two years' membership; Life membership requirements were modified to 50 years' medical practice with last 15 as an active IMS member.

DECLINE PROJECT . . . The House declined support for a Blue Cross-proposed "pilot project" wherein Title XIX recipients in two specified counties would have medication needs met and followed closely by a selected pharmacist who would counsel regularly with the attending physician. In turning down the proposal, the House did underscore the importance of active interprofessional communications.

EMERGENCY SERVICE . . . The House endorsed the concept of categorizing emergency medical services in Iowa, but urged further study of the proposed categorizations and category criteria. Also supported by the House was the general concept of authorizing formally trained and certified mobile intensive care personnel to perform certain lifesaving procedures under specified conditions set by the responsible medical organization.

PROFESSIONAL LIABILITY . . . Through The Prouty Company, IMS group insurance administrator, proposals have been invited for an IMS sponsored professional liability insurance program. Aetna, Travelers and Hartford have been requested to make proposals to Medico-Legal Committee in early 1974. The Committee will report to the House of Delegates next April.

IMMUNIZATION . . . Society representatives participated October 1 in 10 press conferences in Iowa cities to stress importance of immunizations. October was designated Immunization Action Month. Maternal and Child Health Committee aided the State Department of Health in arranging for physician participation.

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THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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Postmaster, send form 3579 to the above address.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Important note: **Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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Highlights—1972 Iowa Physician Survey

Iowa physicians are 55.4% specialists. 14.2% are over 65 years of age, and 10.7% are under 35. The statewide population-physician ratio is 1,258:1. These are among findings of a recent survey made as part of the licensure renewal process.

GURU S. BALE, Ph.D.
Des Moines

Effective planning to meet health manpower needs is dependent on the availability of current and valid data. Since 1906, the American Medical Association has been a source of information on the location, specialty and professional activities of doctors of medicine. However, there has emerged a great need for comparable data which can be used to measure annual changes in the physician population. To meet this need, the AMA Department of Survey Research of the Center for Health Services Research and Development has conducted a series of area-wide surveys of the distribution of physicians. As a result, comparable data were published for each year since 1963. The eighth edition in this series, *Distribution of Physicians in the United States, 1970* was published in 1971.

The AMA directory was the only source for obtaining the number of physicians in Iowa until 1967. In that year, John D. McQueen, M.D., Chairman, Health Manpower Committee, Iowa Comprehensive Health Planning, on the basis of information compiled from the AMA directories of physicians, alerted the Iowa medical community to the existing inequalities in the distribution of physicians practicing in the State of Iowa. Since then there has been a continuing concern over the lack of health information, particularly data relating to health manpower. The State of Iowa Comprehensive Health Planning Council, recognizing the problem, charged its Standing Committee on Health Manpower with the task of obtaining relevant information. The committee contracted with the University of Iowa to undertake the research necessary in order to analyze the patterns and trends of Iowa health manpower resources. The findings of the jointly sponsored research are published in *Health Manpower Resources: Patterns and Trends* (1970) by Mario F. Bognanno, James R. Jeffers and Calvin A. Siebert. This comprehensive study provides useful information on 15 health occupations in Iowa. Additional published information is available through the National Center for Health Statistics, National Institute of Health, Bureau of Health Professions—Education and Manpower Training and the National Institute of Mental Health. It should be noted that the basic information included in these reports has been assembled from the directories of professional organizations. The directories seldom include information on new physicians, exclude non-members and membership does not mean the physician is licensed to practice in Iowa.

Consequently, the available physician information is highly specific, and, to a large extent, limited in scope. This situation led the Iowa State Department of Health to undertake an Iowa physician manpower survey. Physicians, except those in Federal agencies or facilities, must be licensed to practice in Iowa by the State Department of Health. The license must be renewed annually. The Records and Statistics Division, each year, mails renewal applications to all physicians licensed the previous year. In 1972, the mailing included a questionnaire and a letter from the Commissioner of Public Health.

The purpose of the survey was to collect basic information on physicians who practice in Iowa. Annually, approximately 6,000 physicians renew their licenses, but of those physicians only about 2,500 practice in Iowa. In-

Dr. Bale is a member of the Records and Statistics Division of the Iowa State Department of Health.

formation was collected on such categories as geographic distribution, type of specialty, and other pertinent facts about the practicing physicians.

SURVEY RESULTS

According to the survey, there are 3,042 physicians (M.D.'s, D.O.M.S. and D.O.'s) in Iowa. Of these, 2,904 (95%) responded by returning the questionnaire. Among the non-responding physicians, 78 are in private practice and 60 are not in private practice (non-responding physicians were excluded from the analysis since information on office location was not available in the professional directories). Physicians not in private practice include those in: Administration, Teaching and Research, Residency, State and Federal Institutions, and Armed Forces.

Of the 2,904 respondents, 77.3% (2,244) are in active practice, 18.1% (525) are not in private practice and 135 are retired from practice. Johnson and Polk counties have 419 (14.4%) and 440 (15.1%) physicians, respectively. Black Hawk, Linn, Scott and Woodbury counties each have more than 100 physicians. These six counties have 48.4% of all the physicians in Iowa. Polk County has 74 physicians who are not in private practice. Johnson County has 352 physicians who are not in private practice, most of whom are associated with The University of Iowa College of Medicine. The remaining 99 physicians in Iowa who are not in private practice are mostly in counties where State institutions are located.

Of the Iowa physicians, 50.8% (1,474) are graduates of a school in Iowa, and 24.4% (709) served their internship in Iowa. Among the physicians who graduated elsewhere, 16.5% served their internship in Iowa.

There are 1,609 (55.4%) physicians who are in specialty practice. Of these physicians, 57% (917) are certified by a specialty board, 21.3% (342) are eligible for certification and the remaining 350 physicians are general practitioners who limit their practice. The number of physicians by specialty and specialty board status is shown in Table 1.

Among the 2,769 active physicians, 14.2% (394) are 65 years of age and above and 10.7% (297) are under 35 years of age. Of the physicians in specialty practice (1,620 physicians), 9.1% (147) physicians are 65 years of age and above as compared to 21.4% (247) of general practitioners. Physicians under 35 years of age for the two groups total 13.0% (210) and 7.6% (87), respectively. There are very few (4.4%) specialty physicians under 35 years of age in private practice, probably because of

TABLE 1

NUMBER OF PHYSICIANS* BY SPECIALTY AND BOARD STATUS

Physician Survey—Iowa, 1972

Specialty	Total	Board Status		
		Certified	Eligible	GP With Limitations
Total	1,609	917	342	350
Anesthesiology	98	46	29	23
Dermatology	38	23	6	9
General Surgery	216	152	35	29
Internal Medicine	259	124	85	50
Obstetrics-Gynecology	108	69	15	24
Ophthalmology	90	51	23	16
Orthopedic Surgery	63	42	12	9
Otolaryngology	61	36	13	12
Pathology	78	68	5	5
Pediatrics	84	60	13	11
Psychiatry	155	65	53	37
Radiology	129	86	16	27
Urology	54	39	9	6
Other Specified	66	35	12	19
Not stated	110	21	16	73

* Excludes 11 semi-retired physicians.

the time required for residency or because they began their residency after a period of general practice. Of general practitioners in private practice, there are 7.4% (82) under 35 years of age. Also, 21.3% (236) of general practitioners in private practice are 65 years of age and above compared to 10.9% (123) of specialists. There are 936 specialists in private practice in the age group of 35 to 64 as compared to 769 general practitioners. Age groups and types of practice are shown in Table 2.

PHYSICIANS IN PRIVATE PRACTICE

There are 2,244 physicians in private practice, including 34 physicians who are semi-retired from practice. Of these, 49.4% (1,104) are general practitioners and 50.6% (1,140) are in specialty practice. A total of 101 physicians did not indicate their field of specialty. However, these physicians did indicate that they are general practitioners limiting their practice. Number and average age of physicians in private practice by county is shown in Figure 1.

Physicians in specialty practice are concentrated in 18 counties (Figure 2). These counties have 89.5% (1,013) of all specialists and 10.5% (118) are in 56 counties. There are no specialists in 25 counties. Further, the counties with the largest concentration of specialists have 42.5% (459) general practitioners, with the remaining 620 general practitioners in the other 81 counties. These figures exclude 34 semi-retired physicians.

The counties with the concentration of physicians in specialty practice have 53% (1,399,276) of the total population and several large hospitals. Two of the counties, Johnson and Polk, have a College of Medicine and a College of Osteopathic Medicine and Surgery.

POPULATION-PHYSICIAN RATIOS

Population-physician ratios are used as an index of the availability of physician services. A population-physician ratio of 1,500 to 1 is considered accessible to physician services, and any upward departure from this ratio is not readily accessible to physician services.

Many studies have used this criterion in determining the shortage areas. This method has

TABLE 2

NUMBER AND PER CENT OF PHYSICIANS IN PRIVATE AND NOT IN PRIVATE PRACTICE BY SPECIALTY AND GENERAL PRACTICE AND BY AGE GROUPS
Physician Survey—Iowa, 1972

		Age Groups										
	Total	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and Over	Not Specified
All Physicians	2,769	69	228	326	366	370	408	296	253	214	180	59
In private practice	2,244	20	112	238	320	328	347	249	218	193	167	52
Not in private practice	525	49	116	88	46	42	61	47	35	21	13	7
All Specialists	1,620	52	158	219	228	227	251	173	131	73	74	34
In private practice	1,140*	3	47	135	185	187	195	131	103	58	66	30
Not in private practice	480†	49	111	84	43	40	56	42	28	15	8	4
General Practitioners	1,149	17	70	107	138	143	157	123	122	141	106	25
In private practice	1,104‡	17	65	103	135	141	152	118	115	135	101	22
Not in private practice	45	—	5	4	3	2	5	5	7	6	5	3
	Per Cent Distributions											
All Physicians	100.0	2.5	8.2	11.8	13.2	13.4	14.7	10.7	9.1	7.7	6.5	2.1
In private practice	100.0	0.9	5.0	10.6	14.3	14.6	15.5	11.1	9.7	8.6	7.4	2.3
Not in private practice	100.0	9.3	22.1	16.8	8.8	8.0	11.6	8.9	6.7	4.0	2.5	1.3
All Specialists	100.0	3.2	9.8	13.5	14.1	14.0	15.5	10.7	8.1	4.5	4.6	2.1
In private practice	100.0	0.3	4.1	11.8	16.2	16.4	17.1	11.5	9.0	5.1	5.8	2.6
Not in private practice	100.0	10.2	23.1	17.5	9.0	8.3	11.7	8.8	5.8	3.1	1.7	0.8
General Practitioners	100.0	1.5	6.1	9.3	12.0	12.4	13.6	10.8	10.6	12.2	9.2	2.2
In private practice	100.0	1.5	5.9	9.3	12.2	12.8	13.8	10.8	10.4	12.2	9.1	2.0
Not in private practice	100.0	—	11.1	8.9	6.7	4.4	11.1	11.1	15.6	13.3	11.1	6.7

* Includes 9 semi-retired physicians. † Includes 2 semi-retired physicians; ‡ Includes 25 semi-retired physicians.

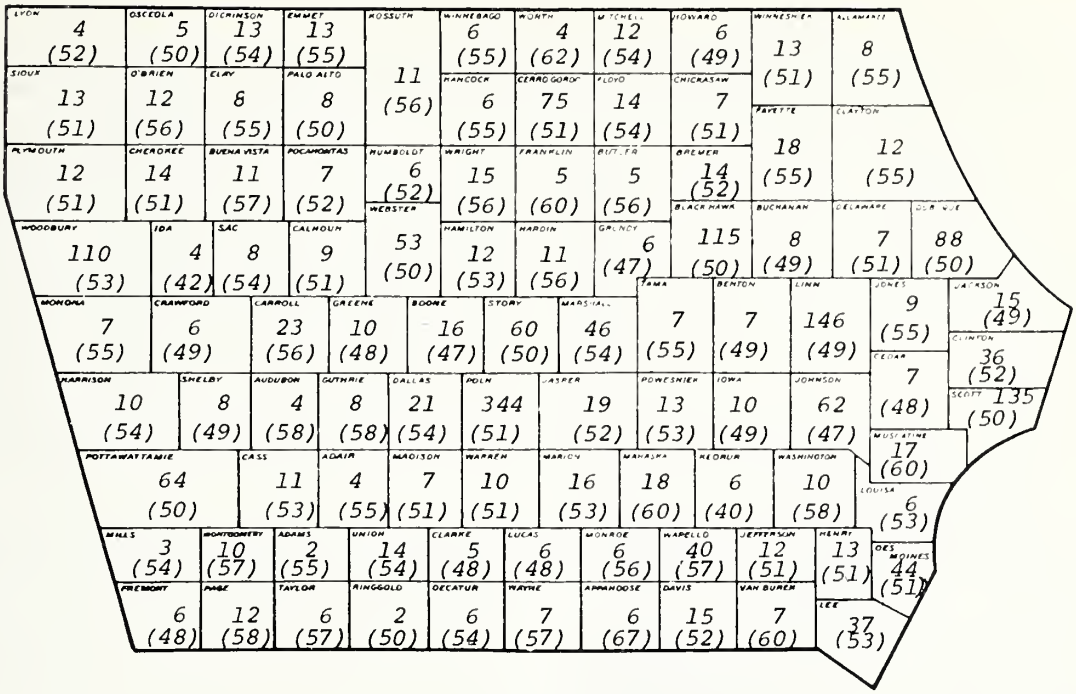


FIGURE 1

NUMBER AND AVERAGE AGE OF PHYSICIANS IN PRIVATE PRACTICE BY COUNTY
Physician Survey—Iowa, 1972
STATE: Total number of physicians—2,244
Average age—52

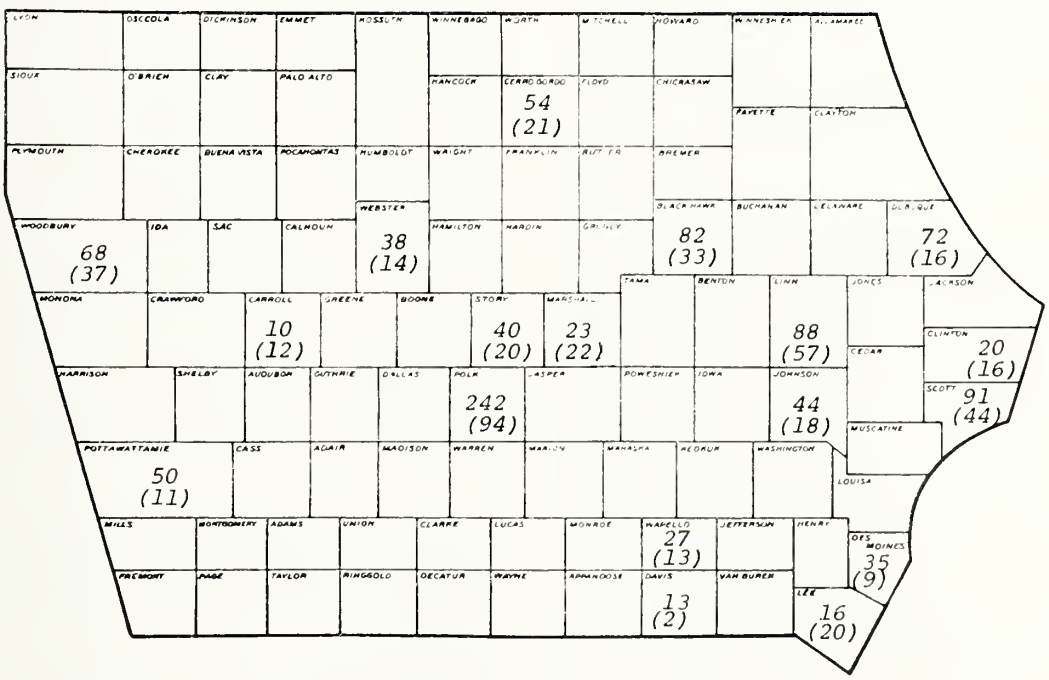


FIGURE 2

NUMBER OF PHYSICIANS* IN SPECIALTY PRACTICE AND GENERAL PRACTICE† FOR SELECTED COUNTIES
Physician Survey—Iowa, 1972

* Excludes physicians semi-retired (9 in specialty and 25 GP's).
† Number of physicians in general practice is shown in parenthesis.

TABLE 3

DISTRIBUTION OF PHYSICIANS BY SIZE OF CITIES

Population Size of Cities	Number of Cities	1970 Population*	Number of Cities	1970 Population	Number of Cities With Physicians: All Physicians	Physicians In Private Practice	Physicians Not in Private Practice
Total	951	2,825,000	349	1,841,000	2,769	2,244	525
Less than 1,000	703	266,545	126	84,000	148	147	1
1,000-2,500	137	215,000	115	182,000	215	211	4
2,500-5,000	48	169,000	44	156,000	188	187	1
5,000-7,500	23	144,000	22	138,000	194	148	46
7,500-10,000	13	109,000	13	109,000	130	124	6
10,000 or more	27	1,172,000	27	1,172,000	1,894	1,427	467

* Column figures do not add to total since the figures excludes unincorporated cities, population living on farms and cities not listed on the Iowa official highway map.

draw-backs; it does not take into consideration the service capabilities of physicians because of age and/or other limitations. Because of the inadequacy of this criterion, several criteria were used in determining the availibility of physician services. The population-physician ratios for this survey were computed for: 1) physicians in private practice and 2) physicians under 65 years of age in private practice. The ratios for Iowa are 1,258 and 1,500, respectively. The state population-physician ratio of 1,258 per physician in private practice and 1,500 per physician under 65 years of age in private practice does not indicate physician shortages in the state. However, the ratios by counties show that 53 counties do not meet the 1,500:1 criterion for physicians in private practice and an additional 22 counties fail to meet the criterion for physicians under 65.

TABLE 4

PHYSICIAN-POPULATION RATIO BY SPECIALTY FOR THE STATE OF IOWA, THE KAISER-PERMANENT PLAN OF OAKLAND, AND THE HEALTH INSURANCE PLAN OF NEW YORK

Physician Survey—Iowa, 1972

Specialty*	Physician Survey Iowa, 1972	Group Plan: Kaiser-Permanent Plan[1]	Group Plan: Health Insurance Plan[1]
Anesthesiology	1: 34,440	1:31,290	—
Dermatology	1:108,620	1:34,642	1:100,000
General Surgery	1: 15,780	1:13,288	1: 16,666
Internal Medicine	1: 16,710	1: 3,244	1: 4,114
Obstetrics-Gynecology	1: 34,860†	1:10,430	1: 9,090
Ophthalmology	1: 44,120	1:32,333	1: 33,333
Orthopedic Surgery	1: 60,090	1:22,045	1: 25,000
Otolaryngology	1: 65,670	1:42,174	1: 50,000
Pathology	1: 49,540	1:64,238	—
Pediatrics	1: 51,340‡	1: 6,101	1: 4,545
Psychiatry	1: 48,690	1:48,500	1: 50,000
Radiology	1: 32,460	1:27,714	1: 25,000
Urology	1: 64,180	1:69,286	1:100,000
General Practitioners	1: 2,610	—	—
Optimum physician population ratio for group	1: 1,260	1: 978	1: 1,000

1. Mason, H. R.: Manpower needs by specialty. J.A.M.A., 12:1,621, 1972.

* See Specialty Definitions: Includes only physicians in private practice: Excludes general practitioners who limit their practice.

† 1:17,920 for female population; 1:6,849 for female population 15-44 years of age.

‡ 1:14,668 for pediatric population 0-14 years of age.

The distribution of physicians by size of city indicates that a majority of cities with a population of less than 1,000 have no physicians. There are 703 cities listed on the Iowa highway map with less than 1,000 population; of these, 126 cities each have a physician, with 148 physicians in all. Except for 27, cities with a population of more than 1,000 each have physicians. Most of the larger cities without a physician are suburbs of a metropolitan area with physician concentration. Distribution of physicians by size of cities is shown in Table 3.

The population-physician ratios by specialty were computed for selected specialties (Table 4). These ratios were compared with two prominent group plans.

This survey reveals much needed information on the licensed physician not available previously. In spite of this, it is difficult to identify factors which play a vital role in the health delivery system. Clearly, many factors affect the availability of health services, such as transportation to the clinic and hospitals, cost of service and socio-economic characteristics of the community. Since information on these is not available, efforts should be made to collect and correlate them with the physician information in the county in future studies.

IOWA MEDICAL MISCELLANY

(Continued from page 512)

MANPOWER . . . Society and Scanlon Foundation representatives met recently with Health Commissioner Norman Pawlewski to consider idea of the State Department of Health to create an Iowa Health Corps. Thought is to contract with medical students, support them financially, all in return for their agreement to practice in a rural community for two years. Discussions are planned with medical students to solicit reactions.

CANCER CENTER . . . Iowa Cancer Epidemiology Center has been established at The University of Iowa College of Medicine under a $241,493 one-year contract with the National Cancer Institute.

BASIC SCIENCE EXAM . . . Abolishment of the Basic Science Board and Exam July 1 was followed by large influx of chiropractic exam applicants. Eighty-three individuals applied to take the exam in July as compared to eight the previous month.

TV SERIES . . . Nationally-produced 5-part TV series entitled "The Killers" will be aired beginning November 19 (at 7 p.m.) over the Iowa Educational Broadcasting Network. The 90-minute programs will cover heart disease, inborn genetic defects, trauma, cancer and pulmonary disease.

HMO ACTIVITY . . . Central Iowa Health Services, Inc., has advised the Society of its early efforts to form an HMO. The private, non-profit agency is explaining its plans to interested parties.

VD TASK FORCE . . . Society President Rubin Flocks, M.D., has been appointed to the Governor's Task Force Against Venereal Diseases. Mrs. Max Olsen, an active Auxilian, was also named.

SPORTS CONFERENCE . . . Planning for 1974 Conference on Medical Aspects of Sports moved ahead October 25 at a meeting of IMS Committee on Sports Medicine. The conference for coaches, trainers, physicians, etc., will be April 4 at the Des Moines YMCA.

HEALTH PLANNING . . . First draft of the OCHP Comprehensive Health Plan for the State of Iowa was reviewed October 25 by the Committee on Delivery of Health Services.

GROUP PROGRAM . . . Proposal for an upgraded Statewide Physicians Group Program was presented by Blue Cross/Blue Shield October 24 to the IMS Group Insurance Committee. Evaluation of the current program has been underway for past year.



HIPPOCRATES' TREE . . . J. F. Bishop, M.D., IMS Board Chairman, right, receives sapling from the great Tree of Hippocrates. Presentation was made by Don Hartnett, Des Moines representative of Schering Laboratories. The famed Tree of Hippocrates grows on the Greek Island of Cos and is reputed to be over 2,400 years old. Schering purchased the seedling trees for distribution to medical organizations throughout the country and in support of the Medical Foundation of Cos.

CHIROPRACTIC . . . The State Board of Health has directed that a study be made of chiropractic. Pending legislation to alter the chiropractic practice act stimulated the study. Board will use a committee to conduct the study. Society representatives have met with Health Commissioner Pawlewski regarding medical representation on the study committee.

UCR EXPERIENCE . . . Through August total monthly payments under Blue Shield Usual, Customary and Reasonable (UCR) program fell between 94 and 97 per cent of the charges as submitted.

Medicaid and Iowa Physicians

The following is the first in a series of discussions on aspects of Iowa's Medicaid program which should be of interest to physicians. Described here is the intermediate nursing care coverage which has been added this year.

On January 1, 1973, the State of Iowa added intermediate nursing care to its Medical Assistance (Title XIX) program. The Intermediate Care Facilities program affords nursing home care to individuals who do not require the degree of care and treatment available in a skilled nursing home, but who, nevertheless, do require professional nursing services on a regular, frequent basis.

Using the designations of the State Health Department, two types of nursing homes are included in the intermediate care facilities program: basic nursing homes and intermediate nursing homes. The primary distinction between these two types of nursing homes is in the amount and kind of nursing services provided. In an intermediate nursing home, nursing care is directly available to all patients 24 hours a day, seven days a week, while in a basic nursing home, patients have direct access to nursing services only 8 hours a day, seven days a week. Intermediate nursing homes provide more comprehensive nursing care than the basic nursing homes. The nursing services in intermediate nursing homes include those that must be carried out or supervised by a registered nurse, while a basic nursing home offers only the nursing services an LPN can provide.

There are aspects of the new program that involve physicians. The federal law which added intermediate nursing care to the Medical Assistance program, P.L. 92-223, requires the state agency administering the Medicaid program to determine there is a "medical necessity" for each individual's admission to an intermediate care facility, and that a "written plan of services" has been developed for the individual before the state may authorize payment for nursing home care.

PHYSICIAN INVOLVEMENT

To comply with these requirements, the Department of Social Services has developed a medical form (MA-2130-0), to be completed for each public assistance recipient entering a nursing home. This form is initiated by the county offices of the Department of Social Services and sent to the recipient's physician. The physician is asked to list the diagnosis and plan of treatment for the recipient, to indicate whether basic or intermediate nursing home care is required, and to estimate the approximate length of time nursing home care will be required. The physician then forwards the form to the nursing home. The nursing home adds its nursing care plan for the recipient and sends the form to the Department of Social Services. Upon determination that there is a medical need for nursing home care, the Department authorizes payment for care in the nursing home.

Once an individual is placed in an Intermediate Care Facility, the federal laws governing the Medicaid program require the state to make periodic re-evaluations of his need for nursing home care. The purpose of these reviews is to prevent the over-utilization of nursing homes. The overall costs of the Medicaid program have skyrocketed in recent years, and much of it is directly traceable to the costs of nursing home care. In fiscal year 1974, the State of Iowa will spend over $33 million of its $67 million Medicaid budget on nursing home care, and the costs are expected to increase sharply in fiscal year 1975. In an effort to control these rising costs, Section 207 of P.L. 92-603 (H.R. 1), which went into effect on July 1, 1973, specifies that for an individual to maintain his eligibility for nursing home care under

the Medical Assistance program, his physician must recertify *at least every 60 days* that he medically requires nursing home care. If these recertifications are not made, federal participation in the cost of care for the individual is reduced by one-third.

THREE APPROACHES

With over 10,000 Medical Assistance recipients presently receiving care in intermediate care facilities, the Department appreciates that this requirement for recertification places a tremendous burden on the physicians in the state. In an effort to minimize this burden, the Department has developed three different procedures that may be used for this recertification. Each physician may use the method or methods most convenient. In cases where the physician is familiar with the individual's current medical condition, a telephoned order that nursing home care be continued, which is recorded on the patient's medical chart, will be sufficient. As an alternate, the physician may review the individual's medical records and order continued care. If the physician feels that it is warranted, the recertification may be made on the basis of a medical examination of the recipient.

In addition to these recertifications by the individual's physician, P.L. 92-223 requires the Department of Social Services to conduct "independent professional reviews" of the care being provided by Intermediate Care Facilities. The purpose of these reviews is to insure that Medical Assistance recipients are receiving proper high quality care in accordance with their physician's written orders.

REVIEW FOUR TIMES

To comply with this requirement, each recipient in a nursing home is reviewed four times a year by a state review team composed of a registered nurse and a social worker. The purpose of these reviews is two-fold. First, the team reviews the adequacy and appropriateness of the care being given the recipient, checking both to be sure the recipient receives all needed services, and to be sure that no unnecessary or excess services are being provided. Second, the team tries to assure that the recipient is helped to achieve and maintain the living arrangement that is best suited to his needs. During each review, the team considers the necessity and desirability of the continued placement of the recipient in an intermediate care facility. The adequacy of the services available in the institution are analyzed both to determine if the current health care needs of the recipient are being met, and to promote the maximum physical, psychological and sociological well-being of the recipient. The team also explores the feasibility of meeting the recipient's health care needs through alternative types of living arrangements such as an adult foster home or possibly a return to an independent living arrangement.

TRANSFER ARRANGEMENTS

When it is determined that nursing home placement is not the most appropriate living arrangement for the recipient, the team will work with the recipient and the County Department of Social Services to effect a transfer. They will also help the county worker arrange for any necessary supportive services. It is hoped many of the persons presently living in an institutional setting can be helped to achieve a more independent living arrangement.

When the team determines a nursing home is the most appropriate living arrangement for a recipient, the team will work to help the nursing home provide an individualized, meaningful existence for the person. The team will concentrate on assuring that the recipient receives all necessary health care and social services to maintain optimal physical, mental and psycho-social functioning. They will act as a resource, working with the nursing home to improve nursing care, helping the home obtain additional social services for its residents, and marshalling volunteer groups and community organizations for nursing home work. In this way, the overall quality of nursing care in the state can be gradually upgraded.

SERVICE TO OLDER PEOPLE

The Department of Social Services feels the implementation of the Intermediate Care Facilities program is the first step in improving the services provided to the older citizens of the state, and sees it as part of the network of services that must be built if we are to meet our obligations to this group of people.

NEEDED: SUICIDE CRISIS INTERVENTION CENTERS

In late 1968 the Maternal and Child Health Division of the Iowa State Department of Health, noting the apparent need for a suicide prevention activity, began to evaluate and correlate information obtained from poison report forms received from Iowa's accredited reporting centers. Iowa has poison information and treatment centers in Des Moines, Iowa City and Fort Dodge and 43 accredited poison treatment centers in hospitals over the state. Most, but not all, of the centers submit reports to the State Department of Health. Many of the reports provide only minimal information. There is no reporting of cases of poisoning treated by private physicians or by hospitals not associated with poison treatment centers. Seven hundred and one cases of poisoning with suicidal intent were reported in calendar years 1969 and 1970 from report forms received.

Of 684 suicidal attempts and suicides by drugs, chemicals and inhalation (other than carbon monoxide), which could be classified by age and sex (17 of the 701 were not so classified), 180 were by men and 504 by women. Of the 180 incidents by men, 93 were in the age group 15-24; of the 504 by women, 263 were in the age group 15-24 years.

MARITAL STATUS AND SEX

	Male	Female	Total
Single	104	13	117
Married	291	99	390
Widowed	59	43	102
Divorced	36	10	46
Unknown and N.S.	2	0	2
Total	492	165	657

Drugs, chemicals and inhalation accounted for 10.5% of all deaths by suicide in the period 1969-70:

PERCENTAGE OF SUICIDES BY ALL METHODS

	Percentage	Number of Male	Number of Female
1. Firearms	48.6	284	35
2. Hanging, strangulation and suffocation	21.0	104	34
3. Motor exhaust gas	12.3	54	27
4. Poison ingestions combining all drugs, chemicals, etc.	10.5	19	50
5. Submersion (drowning)	3.0	11	9
6. Unspecified means	1.8	5	7
7. Cutting and piercing instruments	1.1	6	1
8. Jumping from high places	0.9	5	1
9. Carbon monoxide except from motor vehicle	0.6	3	1
10. Late effect	0.2	1	0
Total	100.0	492	165

AGE

Age	Male	Female	Total
0-4			
5-9			
10-14	4		4
15-19	21	3	24
20-24	22	8	30
25-29	27	9	36
30-34	22	10	32
35-39	36	10	46
40-44	31	14	45
45-49	41	15	56
50-54	46	19	65
55-59	58	19	77
60-64	42	17	59
65-69	46	14	60
70-74	42	9	51
75+	54	18	72
Total	492	165	657

Of the 657 suicides, 183 or 28% were age 65 and up. Today, researchers indicate there are more than 25 million people over 65 in the United States, and they have one of the highest suicide rates of any age group—and the fastest growing poverty rate.

The Iowa State Department of Public Safety statistics of single occupancy (driver) vehicle deaths by age and sex for calendar years 1969 and 1970 are as follows:

Age	Male	Female	Total
15-19	84	18	102
20-24	97	14	111
25-29	43	8	51
30-34	38	9	47
35-39	33	6	39
40-44	25	11	36
45-49	37	9	46
50-54	26	9	35
55-59	23	5	28
60-64	13	7	20
65-69	18	4	22
70-74	17	4	21
75+	35	3	38
Unknown and N.S.	2	0	2
Total	491	107	598

The methods of death were shown as:

Single occupancy driver collided with another moving vehicle (Includes trucks and automobiles)	222
Single occupancy driver ran off roadway	234
Single occupancy driver crashed into fixed object	74
Single occupancy driver crashed into moving or stationary train	44
Single occupancy driver overturned in roadway	16
Single occupancy driver crashed into parked vehicle	17
Single occupancy driver (female, age 39) fell out of moving automobile	1
Total	598

These figures do not include the many motorcycle and tractor deaths which occurred in this period.

Any study and report of suicides and suicide attempts is at risk of unavoidable error since the stigma of suicide still operates to color official reporting. An Iowa insurance official estimates that 40% of single occupancy (driver) vehicle deaths are suicides. Claims men in their reports conclude that investigation of these accidents leads them to believe they are suicide but there is not enough evidence for positive proof. It is suggested that people try to conceal their suicides as traffic accidents, and that more attention to the problem of suicide by auto is needed.

Once every minute, or more often, someone in the United States either kills himself or tries to kill himself with conscious intent. Sixty or 70 times each day these attempts succeed. In many instances they could have been prevented.

This study barely scratches the surface on the estimate of the number of people who daily cry for help in Iowa. From these data it would appear that Iowa is in need of one or more Suicide Crisis Intervention Centers.

The complete report is available on request from the Family Health Service, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Nov. 8	Contemporary Medicine and Social Change (Des Moines)
Nov. 15-17	International Symposium on Eye and Systemic Disease
Nov. 17	Conference on Radiology
Nov. 28-29	Postgraduate Conference on Obstetrics and Gynecology
Nov. 30	Postgraduate Conference on Surgery
Dec. 3-5	Pediatric Nutrition
Dec. 3-6	Cardiology Today
Dec. 5	Ophthalmology Clinical Conference
Dec. 6	What's New in Stroke?
Dec. 7	Cardiac and Respiratory Disease Conference
Dec. 8	Iowa Clinical Society of Medicine

Morbidity Report for September, 1973

Disease	Sept. 1973	1973 to Date	1972 to Date	Most September Cases Reported From These Counties
Actinomycosis	1	1		Woodbury
Adenovirus infection	1	1		Woodbury
Amebiasis	21	75		Dallas, Louisa, Wapello
Chickenpox	66	10847	6530	Scattered
Conjunctivitis	31	841	665	Scattered
Coxsackie B-3 infection	1	1		Polk
Eaton's agent infection	4	15		Buena Vista, Keokuk, Polk
ECHO 6 virus infection	1	1		Johnson
Encephalitis, viral —California	1	1		Winneshiek
Encephalitis, type unspecified	2	13	3	Linn, Scott
Encephalitis, assoc. w/Coxsackie B-4	1	1		Polk
Encephalitis, assoc. w/ECHO 6	1	1		Johnson
Erysipelas	1	4		Linn
Gastrointestinal viral infection	278	5603	4531	Dubuque, Floyd, Johnson
Giardiasis	1	14		Monona
Hepatitis, infectious	7	167	230	Scattered
Hepatitis, serum	7	40	45	Scattered
Hepatitis, type unspecified	4	18		Johnson, Polk
Herpes simplex	6	49		Johnson, Iowa, Linn, Scott
Herpes zoster	3	15		Johnson, Shelby, Tama
Histoplasmosis	3	8	22	Jackson, Jasper, Page
Impetigo	90	282	315	Clayton, Floyd, Linn
Infectious mononucleosis	46	522	671	Scattered
Influenza-like illness	425	11810		Johnson, Linn, Louisa
Meningitis, type unspecified	10	26	18	Jasper, Lee, Scott, Story
Meningo-encephalitis	2	8		Dubuque, Wapello
Mumps	90	3100	5766	Scattered
Pediculosis	31	130		Dubuque, Lee, Louisa
Pneumonia	94	869	660	Scattered
Psittacosis	1	1		Benton
Rabies in animals	20	184	290	Scattered
Ringworm, body	27	27	61	Appanoose, Clayton, Linn
Rubella	4	204	394	Des Moines, Dubuque
Salmonellosis	27	138	144	Scattered
Scabies	5	13		Floyd, Louisa, Muscatine
Shigellosis	41	235	225	Dubuque, Woodbury
Streptococcal infections	373	5118	5229	Johnson, Keokuk, Polk
Tuberculosis, active	10	99	90	Scattered
Venereal Disease:				
Gonorrhea	614	4674	394	Linn, Polk, Scott, Woodbury
Syphilis	50	324	369	Johnson, Lee, Polk, Scott

IOWA MEDICAL MISCELLANY

SOCIETY REP . . . J. E. Tyrrell, M.D., Manchester, is new Society representative on the Advisory Council to the Office of Comprehensive Health Planning. Dr. Tyrrell is one of several physicians named to the revamped Council.

OPENING . . . Formal opening ceremonies for the new Family Health Center at Broadlawns Polk County Hospital occurred September 23. New center will serve as a training site for new physicians seeking special training in family practice.

KELLOGG GRANT . . . A 3-year $495,877 grant has been awarded by the W. K. Kellogg Foundation to the U. of I. College of Medicine to assist in developing the model community health center in Muscatine. Grant will allow the project to become operational this fall. Center will allow for studies of primary health care delivery and serve as a training site for health personnel in an Iowa community of intermediate size.

PUBLIC HEALTH NURSING . . . Eighty-six of Iowa's 99 counties are currently served by public health nurses.

SCIENTIFIC ARTICLES

The Care of Terminal Patients: A Statewide Survey

RUSSELL NOYES, JR., M.D.
TERRY A. TRAVIS, M.D., and
DENNIS R. BRIGHTWELL, M.D.

A BRIEF QUESTIONNAIRE* concerning the care of terminally ill patients was recently distributed to all Iowa physicians. Purpose of the survey was to assess the current management of terminal patients and to discover whether Iowa physicians feel a need for change in existing practices. More specifically, the questionnaire inquired about life-prolonging and death-hastening measures, actions affecting the quality of life in terminal patients. The survey was constructed so as to place these management practices within the context of communication between physicians and their terminal patients.

Dr. Noyes is an associate professor in the Department of Psychiatry, University of Iowa College of Medicine. Dr. Travis is an associate professor in the Department of Psychiatry, Southern Illinois University School of Medicine. Dr. Brightwell is a resident in the Department of Psychiatry, University of Iowa College of Medicine.

* This questionnaire was adapted from one developed by Brown, N. K. *et al:* J.A.M.A., **211**:76-82, 1970.

Three thousand two hundred twenty-three (3,223) questionnaires were distributed, of which 1,602, or 50%, were returned. The responses included 133 from first and fourth year medical students at The University of Iowa, 177 from interns and residents at the University of Iowa Hospitals, and 147 from the clinical faculty of The University of Iowa College of Medicine. One hundred four physicians, who received but did not return questionnaires, were visited by one of the authors at their offices. As a result, 82 completed the questionnaire while 22 preferred not to do so. Sixteen of the latter group explained they did not treat terminal patients.

FINDINGS

The questionnaire data are presented in tables which break down the responses by level of training and specialty. The figures are percentages of physicians answering "frequently" (or "always") to questions 1, 2, and 3 and "yes" to questions 4 and 6. Certain trends in the responses are evident in the totals for all physicians, shown in Table 1. Few physicians

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER, 1973.

TABLE I

PER CENT OF PHYSICIANS ANSWERING FREQUENTLY AND ALWAYS, OR YES

	Students	House Staff	Faculty	Non-University Physicians	All Physicians	Non-Responders
1a. How often do terminal patients realize they are dying?	89	84	80	81	81	78
1b. How often do terminal patients bring up the subject of dying?	13	13	14	16	16	22
2b. How often do you tell patients their prognosis?	51	54	44	54	53	68
3a. How often do patients ask for omission of life-prolonging measures	7	2	4	22	18	14
3b. How often do families ask for omission of life-prolonging measures?	7	11	6	36	30	23
3c. How often do you omit life-prolonging measures?	11	28	29	49	44	42
4a. Favor statement authorizing omission of such measures?	64	44	32	45	44	45
4b. With such a statement would increase omission of such measures?	70	52	34	47	47	41
6a. Favor change in social attitudes about death-hastening measures	50	37	25	26	27	16
6b. Following such a change would provide death-hastening measures?	46	34	22	21	23	13

characterized their communication with terminal patients as open. For example, despite presumably knowing they were dying, relatively few patients (16%) spoke about death. And, with regard to the delicate matter of communicating the prognosis to these patients, widely varied practice was reported (question 2b).

Despite infrequent requests for discontinuation of treatment, 44% of the physicians reported they frequently omit life-prolonging medications or procedures in their management of terminal patients. Only 6% indicated they had never done so. Furthermore, with increased sharing of responsibility for decisions in this area, 47% indicated they would increase this particular practice (question 4b). In contrast to this, a majority of physicians (77%) rejected the idea of providing death-hastening procedures or medications (question 6b) with or without social sanction. Indeed, 54% claimed never to have had a request for an intervention of this type (question 5a).

LEVEL OF TRAINING

Table 1 gives a breakdown of responses to the questionnaire by level of training. In view of their limited experience, medical students were instructed to anticipate their practice in marking the questionnaire. First and fourth year students did not differ from one another; however, both differed from graduate physicians in their responses to a number of questions. Only 11% of students predicted they would frequently omit life-prolonging measures in their management of terminal patients. They did not appear to appreciate the responsibility they would eventually assume in this area. Students, on the other hand, showed the greatest desire for change in social attitudes (question 6a). This may have reflected the social concern of their generation or an attitude unmodified by experience with terminal patients.

Several differences between university and non-university practice were observed. House staff and faculty infrequently (4%) heard requests for omission of life-prolonging measures as compared with non-university practitioners (22%). This may reflect the nature of the doctor-patient relationship in a teaching center. It is influenced, in such a setting, by an emphasis on the diagnosis and treatment of disease and by shared responsibility for patient care. Though less personal, the relationship may carry with it greater expectation of technical competence and may therefore also account for the lesser frequency with which faculty and house staff omit life-prolonging measures: 29% as opposed to 49% for non-university practitioners.

SPECIALTY

Table II shows the questionnaire response by specialty. Responses of a specialty group are related to the frequency with which its practitioners care for terminal patients. Those who infrequently care for them include radiologists, pathologists, psychiatrists, dermatologists, anesthesiologists and ophthalmologists. The responses of these specialists (Table II)

closely matched those of physicians who indicated (question 7) they seldom or never care for such patients. Specialists who often care for terminal patients (including internists, neurologists, obstetricians, surgeons, and urologists) did not differ in their responses from physicians in general practice with one exception. These specialists claimed they omit life-prolonging procedures less frequently (40%) than general practitioners (56%).

In Table II the responses of physicians who frequently care for terminal patients may be compared with those of physicians who rarely look after them. This comparison may indicate what bearing experience has on physicians who deal with terminal patients. To begin with, experienced physicians more often felt terminal patients realize they are dying. They also seemed more prone (56% vs. 35%) to discuss a patient's prognosis with him. Finally, experienced physicians claimed they omit life-prolonging measures twice as often as inexperienced ones (52% vs. 21%). These differences suggest that with experience a doctor grows more comfortable with the responsibility he assumes for the length and quality of patients' lives.

Those physicians having the least contact with terminal patients were the most anxious for change in the manner of dealing with them. For example, 35% of inexperienced physicians favored change in social attitudes permitting initiation of death-hastening measures whereas only 25% of the experienced group were similarly inclined. Despite their interest in change, inexperienced physicians suggested it is easier to talk about the problem than it is to act. While 35% favored change in social attitudes, only 25% indicated they would provide death-hastening measures in the event of change.

TABLE II

PER CENT OF PHYSICIANS ANSWERING FREQUENTLY AND ALWAYS, OR YES

	Specialists (Infrequent)	Specialists (Frequent)	General Practice	Infrequent Contact	Frequent Contact
1a. How often do terminal patients realize they are dying?	76	81	83	73	85
1b. How often do terminal patients bring up the subject of dying	21	14	17	11	18
2b. How often do you tell patients their prognosis?	33	53	55	35	56
3a. How often do patients ask for omission of life-prolonging measures?	8	13	25	7	22
3b. How often do families ask for omission of life-prolonging measures?	12	25	41	12	36
3c. How often do you omit life-prolonging measures?	19	40	56	21	52
4a. Favor statement authorizing omission of such measures?	51	42	44	62	40
4b. With such a statement would increase omission of such measures?	55	45	45	61	44
6a. Favor change in social attitudes about death-hastening measures?	35	29	23	35	25
6b. Following such a change would provide death-hastening measures?	25	26	19	28	21

AGE

A breakdown of questionnaire responses by age revealed a correlation between the responses of youthful and elderly physicians in contrast to those in middle-age. A trend in responses to many questions from the 20's-40's was reversed from the 50's-70's. These findings are difficult to interpret.

Physicians who believe their terminal patients usually realize they are dying were compared with those who feel patients infrequently have such awareness. As one might expect, there appeared to be an association between this belief and the type of doctor-patient interaction. Thus, physicians who believed their patients were aware of their circumstances more readily discussed the prognosis with them (55% vs. 16%) and more frequently omitted life-prolonging measures (47% vs. 29%).

NON-RESPONDERS

Table 1 shows the responses of physicians who did not return the questionnaire following its initial distribution. Their replies were very similar to those initially received. However, responses to questions 6a and b were exceptions. Less of the non-responding physicians (16% vs. 27%) favored change in social attitudes and fewer of them were prepared to provide death-hastening measures in the event of change (13% vs. 23%). These findings sug-

gest that those physicians who did not respond to the questionnaire represent a more conservative group. The fact that they were less in favor of social change no doubt influenced their behavior with respect to returning the questionnaire.

COMMENT

A few general conclusions may be drawn from the data. First of all, experience with terminal patients proved a strong determinant of management practices and desire for change. This was evident not only from a comparison of students with graduate physicians but also from a comparison of experienced with inexperienced physicians. The greater a physician's experience, the more likely he was to omit life-prolonging measures (question 3c). Also the greater his experience the less need he felt for change in his practice or in social attitudes (questions 4a and 6a). Perhaps repeated exposure reduces a physician's anxiety and enables him to deal with terminal patients more openly and directly. On the other hand, anxiety over the assumption of responsibility for seriously ill patients may have been a factor influencing specialty choice for physicians having limited exposure to such patients.

An association was observed between the character of communication between a physician and his dying patients and that physician's management of terminally ill persons. If, as seems likely, . . . more open discussion of death should develop between physicians and terminal patients, more frequent requests for discontinuation of treatment could be anticipated. Regardless, however, of how patients and their families look upon the problem, close to half of the physicians in Iowa desire an environment more favorable to this practice (question 4b).

By way of contrast, there was little desire expressed for change in social attitudes to allow for the provision of death-hastening measures (question 6a and b). Only 21.5%† of Iowa physicians favored change in attitudes that would support such a practice and, in the event of a change, only 18%† would consider interventions of this type. Those who commented were almost universal in their opposition to this practice.[1]

The results of this study are like those of Brown, *et al* and Laws, *et al*, who distributed a similar questionnaire to first and fourth year medical students at the University of Washington.[2,3] An identical 46% of students from both institutions felt that, if change in social attitudes occurred, they would provide death-hastening measures (question 6b). Indirect evidence from this study suggests the attitudes of these students may change as their careers progress and as they are influenced by experience with terminal patients.

SUMMARY

A brief questionnaire on the care of terminal patients was distributed to Iowa physicians. The response suggests Iowa physicians believe terminal patients often realize they are dying although they rarely speak of it. Nearly half of the physicians acknowledged omitting life-prolonging procedures or medications in the care of these patients. Likewise, close to half indicated that, with increased sharing of responsibility for such decisions, they might increase the frequency of this particular practice. However, the vast majority expressed opposition to change in social attitudes which would permit physicians to hasten death. Analysis of responses to the questionnaire revealed the influence of experience upon the practices of Iowa physicians and upon their desire for change. With greater exposure to terminal patients, they more readily discussed a patient's prognosis with him, more often received requests for interruption of treatment, and more frequently omitted life-prolonging measures.

REFERENCES

1. Noyes, R., Jr., and Travis, T. A.: Care of terminal patients. Arch. Int. Med., **132**:607-611, 1973.
2. Brown, N. K., *et al:* Preservation of life. J.A.M.A., **211**: 76-82, 1970.
3. Laws, H. E., *et al:* Views on euthanasia. J. Med. Educ., **46**:540-542, 1971.

† This figure combines the responses of physicians who originally returned questionnaires with those who did not.

Metabolic Effects of Training Practices On High School Wrestlers

W. H. OEHLERT, M.D.,
H. R. JORDAN, and
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Iowa City

In Iowa, approximately 6,000 students belong to more than 260 high school wrestling squads.[1] Thus, it is not infrequent that physicians are called upon to certify the health of boys at the beginning of the school year so that they can compete in wrestling. When a physician certifies the health of a high school student for competitive wrestling, he is permitting the boy to undertake a rigorous training program which includes not only physical conditioning, but also periods of fasting and dehydration which are the methods used by many wrestlers and their coaches to allow them to weigh in at the lowest possible weight class. These practices resulting in weight loss are based upon the premise that a larger boy who loses weight is able to perform better than another boy whose weight is naturally at the same level. The extent of weight reduction is on occasion determined by the wrestling squad's representation in different weight classes.

The purpose of this study was to observe the effects of a training program for high school wrestlers on their metabolic state at the time of "weigh-in," when maximal weight loss is obtained by training, fasting and water deprivation. No attempt was made to interfere or regulate training practices in any way. Weigh-in day is a designated day, usually in early December, when a wrestler gets weighed and this is the lowest weight at which he can wrestle during the season. Weigh-in day was chosen because it was felt that these boys would be at their minimum weights and exhibit the maximum amount of change, if any.

This paper has been provided by the Section on Pediatric Cardiology, Department of Pediatrics, University of Iowa College of Medicine. Since the preparation of the paper Dr. Oehlert has become Director of the Coronary Care Unit at the Veterans Hospital in Oklahoma City, Oklahoma. The study reported here was supported by a grant from the Iowa Heart Association.

METHOD

Twenty-five wrestlers from three high schools, directed by three different coaches, were studied. The boys ranged from 15 to 17 years. Ten from one school were examined initially during the early phase of their training and a second time on the weigh-in day. Fifteen from two other schools were examined on a day prior to a wrestling meet when the wrestlers were again expected to meet their original weigh-in weights.

All wrestlers in the study had a medical history and general physical examination. Triceps skin fold thickness was measured as an index of body fat. Hand strength as measured by dynanometer was used as an index of motor strength.[2] A urine sample was analyzed for pH, sugar, protein, specific gravity and osmolarity. A venous blood sample was obtained and analyzed for pH, pCO_2, hematocrit, sodium, potassium, chloride, bicarbonate, blood urea nitrogen (BUN), creatinine, uric acid and serum osmolarity. All urine and blood examinations were performed by standard clinical laboratory techniques at University Hospital, Iowa City, Iowa.

RESULTS

Table I shows the data obtained from 10 boys who were examined early in training and again at the time of weigh-in. The weights ranged from 97 to 193 pounds, with a mean of 139.9 (± 3.1) pounds initially. These wrestlers lost 2.5 to 10.5 pounds, 2.6 to 6.2% of their initial

TABLE I

URINE AND SERUM CHEMISTRIES OF TEN HIGH SCHOOL WRESTLERS BEFORE AND AT WEIGH IN

					DYNAMOMETRY		URINE				BLOOD									
#	Iwt lbs*	Fwt lbs*	△ % wt	SF mm	R mmHg	L mmHg	pH	Prot.	SpGr	mOsm/1	mOsm/1	pH	pCO_2	Hct.	Na	K	Cl	BUN	Cr	Ur.A.
1	97			11.0	32.0	22.0	6.0	Neg	1.026	1129	285	7.35	40	40	145	4.4	106	11	0.8	2.0
		94.5	-2.6	8.2	28.0	21.0	6.0	Neg	1.027	1257	305	7.38	43	42	145	5.3	112	13	1.2	8.0
2	106			6.3	40.0	38.0	6.0	2+	1.034	1185	287	7.38	42	45	143	4.1	104	15	1.0	5.5
		103.25	-2.6	6.7	37.0	36.0	6.0	Trace	1.029	1161	301	7.37	42	44	148	4.9	111	15	1.4	5.5
3	149			5.8	41.0	41.0	6.0	1+	1.032	1072	284	7.40	38	39	144	4.7	100	16	1.6	6.5
		145	-2.7	5.4	43.0	33.0	6.0	2+	1.040	1386	309	7.41	40	42	146	5.6	108	19	1.2	9.0
4	159			6.9	38.0	39.0	6.0	2+	1.035	1156	281	7.38	39	50	142	4.3	102	10	0.8	5.0
		154	-3.1	5.8	43.0	38.0	6.0	2+	1.035	1025	299	7.42	38	48	151	5.1	109	18	1.2	11.0
5	109			10.6	32.5	24.0	6.0	Neg	1.024	833	289	7.45	36	46	142	4.5	104	9	0.4	2.5
		105	-3.7	8.2	30.0	24.0	6.0	Trace	1.029	923	302	7.36	37	45	148	5.5	108	15	1.2	7.5
6	170.5			4.8	50.0	54.0	6.0	Trace	1.032	1148	283	7.35	46	48	142	4.2	102	13	1.4	8.5
		164.25	-3.7	4.1	51.0	53.5	6.0	2+	1.030	940	304	7.39	38	48	143	4.2	114	16	1.4	12.8
7	159			9.0	43.0	44.0	6.0	1+	1.035	1179	287	7.45	28	48	139	4.3	98	15	1.2	9.5
		153	-3.8	5.6	51.0	53.0	6.5	Neg	1.030	926	301	7.36	47	48	147	5.1	113	17	1.2	13.0
8	193			9.4	48.0	47.0	—	—	—	—	286	7.35	44	52	144	4.2	100	16	1.2	9.0
		182.5	-5.4	9.4	51.0	48.0	6.0	1+	1.035	1089	301	7.34	44	51	144	4.3	112	18	1.2	13.0
9	124			6.6	45.5	42.5	5.0	Trace	1.025	1241	294	7.39	48	48	145	4.7	101	16	1.6	6.0
		117	-5.6	4.1	47.0	37.0	7.0	Neg	1.036	1096	299	7.46	31	48	142	4.0	108	19	1.2	5.5
10	114			6.0	44.0	40.0	6.5	Neg	1.022	945	284	7.41	31	44	142	4.3	101	14	1.2	6.0
		107	-6.1	5.2	34.0	31.0	6.0	1+	1.032	844	298	7.36	40	44	147	5.4	117	18	1.6	6.5
Mean & SD *	139.9 3.1			7.6 ±2.2	42.2 ±5.8	39.5 ±8.9	5.95 ±.04		1.029 ±.018	1122 ±128	285.3 ±3.8	7.39 ±.04	38.1 ±6.9	45.8 ±3.9	142.7 ±2.1	4.4 ±.2	101.7 ±2.1	13.75 ±2.6	1.1 ±.3	6.1 ±2.3
Mean & SD **		132.6 ±3.5	-3.93 ±1.24	6.3 ±1.8	41.5 8.8	38.0 ±10.6	6.15 ±.03		1.032 ±.004	1065 ±168	301.9 ±3.3	7.38 ±.04	40.1 ±4.4	46.0 ±3.0	146.1 ±2.7	4.9 ±.6	111.2 ±3.0	16.6 ±1.8	1.3 ±.1	9.1 ±3.0

* First row of values are for the initial examination. ** Second row on the day of weigh in.

BUN = Blood Urea Nitrogen (mg%)
△ = Change
Cl = Chloride (mEq/l)
Cr = Creatinine (mg%)
Fwt = Final weight (lbs)
Hct = Hematocrit (gm%)
Iwt = Initial weight (lbs)
K = Potassium (mEq/l)
l = Liter
L = Left
lbs = Pounds
mm = Millimeters
mmHg = Millimeters Mercury
Na = Sodium (mEq/l)
Osm = Osmolarity
Prot = Protein
% = Percent
R = Right
SD = Standard Deviation
SF = Skin Fold Thickness
SpGr = Specific Gravity
Ur.A. = Uric Acid (mg%)
Wt = Weight

TABLE II

FIFTEEN HIGH SCHOOL WRESTLERS AFTER WEIGH IN

					URINE				BLOOD								
#	Iwt	Fwt	△ %wt	SF	pH	Prot.	SpGr	mOsm/1	mOsm/1	pH	pCO_2	Hct.	Na	K	Cl	BUN	Cr.	Ur.A
1	146	143	-2.1	8.4	6.0	Trace	1.032	1125	293	7.40	40	43	137	3.7	100	12	1.2	13
2	138	132	-4.3	7.2	6.0	Trace	1.032	1169	290	7.35	42	48	137	4.1	102	14	0.7	10
3	141	133	-5.7	4.4	6.5	Trace	1.023	858	300	7.37	34	45	135	3.8	101	12	0.6	12
4	129	121	-6.2	4.8	---	Neg	---	---	290	7.34	43	42	139	4.1	97	17	1.2	9
5	138	128	-7.2	6.3	6.5	1+	1.030	935	295	7.39	34	47	138	3.9	101	15	1.4	4
6	138	127	-8.0	6.4	6.5	Trace	1.031	1217	301	7.38	35	40	137	3.8	105	18	0.2	8
7	132	121.5	-8.0	4.6	---	Neg	---	---	291	7.40	32	48	140	4.0	108	16	0.8	8.5
8	110	101	-8.0	4.6	6.0	Trace	1.025	862	287	7.32	36	46	137	3.5	104	15	1.8	7
9	135	122.5	-9.3	7.6	6.0	Trace	1.032	913	299	7.40	32	47	144	3.7	104	14	1.4	9.5
10	132	119	-9.8	4.5	6.0	1+	1.034	1012	289	7.36	33	40	138	4.6	101	23	1.4	8.5
11	161	145	-9.9	5.0	5.5	1+	1.032	900	294	7.39	40	39	134	4.2	101	22	2.0	15
12	120	108	-10.0	5.1	6.0	1+	1.032	1001	287	7.38	33	41	141	3.7	104	17	1.2	7.5
13	155	138	-11.0	6.3	---	Neg	---	---	304	7.37	42	45	139	3.6	102	21	1.6	11
14	155	138	-11.0	5.9	6.0	1+	1.033	1179	300	7.39	40	44	137	3.7	102	30	1.6	9
15	165	145.25	-11.8	5.2	6.5	Trace	1.030	1093	306	7.41	31	44	148	3.4	109	21	1.4	8
Mean & SD	139.6 ±14.4	128.1 ±12.6	-8.15 ±2.61	5.75 ±1.24	6.1 ±.31		1.030 ±.0031	1036.1 ±133.2	295 ±5.99	7.37 ±.033	36.4 ±4.08	43.9 ±2.9	138.7 ±3.39	3.8 ±.3	102.7 ±2.95	17.8 ±4.85	1.23 ±.48	9.3 ±2.65

For legend see TABLE I

body weight. Triceps skinfold thickness decreased in all but one boy. This wrestler lost 2.6% of his initial weight.

Hand strength showed great variation. Three boys had a decrease in tested strength in both hands, two had an increase in both hands and five had a decrease in one hand and an increase or no change in the other hand. There was no correlation between the change in weight and the results of the hand strength measurements.

The mean urine specific gravity was 1.029 and the mean osmolar concentration was 1122 mOs/l initially and 1.032 S.G. and 1065 mOs/l at the time of weigh-in.

Serum osmolarities were in the high normal range at both examinations but were increased at the time of weigh-in over the initial examinations in all instances; the mean serum osmolarity was 285 mOs/l initially and 301 at the time of weigh-in.

Hematocrits were within the normal range at both examinations and there was no significant change relative to weight loss.

The serum pH ranged from 7.35 to 7.46 with a mean of 7.39. The pCO_2 ranged from 28 to 48 mm Hg with a mean of 39.

Serum sodium levels ranged from 139 to 145 mEq/l initially and from 142 to 151 mEq/l at the time of weigh-in. Serum chloride concentrations increased from a mean of 102 mEq/l to 111 mEq/l.

Serum potassium and bicarbonate concentrations were within the normal range. Potassium ranged from 4.0 to 5.6 mEq/l.

The blood urea nitrogen and serum creatinine stayed the same or increased in all instances. The BUNs ranged from 11 to 19 mg% with a mean of 14 initially and 17 mg% at weigh-in. The creatinines ranged from 0.4 to 1.6 mg% with a mean of 1.1 and 1.3 mg% on the two examinations.

Serum uric acid values showed a rise over their initial values in seven wrestlers at weigh-in. For six of these wrestlers, the serum uric acid exceeded 8.5 mgm% indicative of a moderate degree of starvation.[3]

Table II shows the data from 15 other wrestlers who had blood and urine examinations performed only at the time of weigh-in. These subjects had a weight loss of 2% to 12%, 3 to 19.75 pounds. These boys had findings that were similar to the boys shown in Table I. The urine specific gravity, urine osmolarity and serum osmolarity were elevated but within the normal range.

The uric acids were elevated in several boys, with 10 having values of 8.5 mg% or greater, one of 15 mg%.

The BUN and creatinines were within the normal range except for one boy who had a BUN of 30 mgm%. This was rechecked when he had gained 10 pounds several weeks later and the value was normal.

The serum pHs ranged from 7.32 to 7.41 with a mean of 7.36. The sodiums and chlorides were lower in the second group of wrestlers than the boys shown in Table I: mean sodiums of 139 mEq/l as compared to 146 and mean chlorides of 103 mEq/l as compared to 111 mEq/l. The differences in the serum sodiums and chlorides were significant at a p of less than 0.01. The wrestlers with the higher levels had been provided salt tablets on an ad lib basis. Potassium concentrations were also lower in the second group with a mean of 3.8 mEq/l as compared to 4.9 mEq/l.

When the data from the 25 wrestlers were analyzed together, there was little correlation between weight loss and urine specific gravity, osmolarity, blood osmolarity, pH, hematocrit, sodium, chloride and uric acid. There was a greater relationship between the percent weight loss and blood pCO_2, potassium, creatinine and BUN. The pCO_2 and potassium had a negative correlation coefficient which was significant at a p of less than 0.05 and 0.01 respectively. The creatinine and BUN had a positive correlation coefficient with percent weight loss significant at a p of less than 0.05 and 0.01, respectively. (See Table III.)

TABLE III

CORRELATION OF pCO_2, K, CREATININE AND BUN WITH WEIGHT LOSS

Variable	No.	r With % Wgt. Loss
pCO_2	25	−0.435*
K	25	−0.601**
Creatinine	25	+0.417*
BUN	25	+0.589**

r = Correlation Coefficient
* = Significant p 0.05
** = Significant p 0.01

DISCUSSION

The concern is whether the practice of dehydration and fasting, usually for a period of 3-10 days, to decrease weight in order to qualify for a given wrestling weight class is a harmful practice. The degree of dehydration that these wrestlers disciplined themselves to withstand was high, as manifested by the high urine specific gravities; values were often at the maximum limits for urinary concentrating capacity.

Despite this, all wrestlers showed normal serum osmolarity; and serum electrolytes were, for the most part, within the normal range. A few subjects who took salt tablets had mild elevation of serum sodium and chloride concentrations. The small changes in pCO_2 and potassium observed were inversely related to the percentage of weight loss. All subjects were able to maintain a normal pH.

The decrease in pCO_2, although small, is the result of compensation for the metabolic acidosis that resulted from fasting and dehydration. The decrease in potassium is not readily explainable. One possible explanation is that with the development of metabolic acidosis the wrestlers may develop an initial hyperkalemia and lose potassium in the urine. With the correction of the acidosis by respiratory alkalosis, potassium goes back into the cells and results in a lower normal serum potassium.

It was observed that the increase in creatinine and BUN related to the magnitude of weight loss, but there was little relationship of weight loss to indices of dehydration: urinary specific gravity and osmolarity and serum osmolarity. This suggests that the rise in creatinine and BUN is the result of tissue catabolism as well as to dehydration.

There is little more than anecdotal information about whether a boy is able to wrestle more effectively at a weight class attained through fasting and dehydration than another who weighs in at the same weight without fasting and dehydration. In college age wrestlers, a weight loss of 7% or less resulted in no loss of strength or agility.[4, 5] There was no relationship of grip strength changes to weight loss in the wrestlers observed in this study. However, Reidman[6] states that a 2.5% body water deficit will result in a 25% reduction in work output.

The minimal changes observed in serum electrolytes and osmolarity indicate the practice is probably safe if supervised. In situations where renal function is compromised, fluid restriction of the degree noted in these high school wrestlers may be harmful. No symptoms resulted in the wrestlers of the three high schools studied; however, exhaustion, dehydration, fainting, and pancreatitis have been reported from the training practices of wrestling.[7] All potential wrestlers should be cautioned during training about such practices as prolonged heat exposure (saunas), exercise in rubber suits, prolonged dehydration. self-induced vomiting, use of diuretics, and intake of salt tablets without water replacement—all of which may result in serum dehydration, hypernatremia and clinical symptoms.

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AMA CLINICAL MEETING

The 1973 Clinical Convention of the American Medical Association will be December 1-5 in Anaheim, California. Thirty postgraduate courses will be offered. The scientific program's general session, postgraduate courses and medical films will begin at the Convention Center December 2 and run through December 4. More than 100 scientific exhibits, grouped by subject, will be on display, beginning December 1.

Multiple Leiomyomata With Associated Clitoral Hypertrophy

ROBERT L. BARRICKS, M.D.
Omaha, Nebraska

FOLLOWING IS A CASE REPORT which describes the medical investigation of an asymptomatic clitoral enlargement. In the investigation it was discovered a benign cellular leiomyoma had been removed from the left labium. In addition, the patient exhibited massive esophageal involvement with an identical leiomyoma. Subsequently, she also required removal of a bladder leiomyoma. It is our purpose to discuss the etiology of clitoral hypertrophy. In addition, we will present a review of similar cases, as well as a review of material from the University of Iowa Hospitals regarding vulvar leiomyoma.

G.R. is a 24 year old nulligravida referred to The University of Iowa Hospitals for evaluation of asymptomatic clitoral hypertrophy. Her history revealed adrenarche at age 12 years with menarche at age 13 years. She continued to have a normal menstrual pattern. Physical development was normal. At age 18 years, she sought medical attention for an enlarging labial mass (Figure 1). Symptoms of nausea and vomiting prompted pre-operative upper G.I. x-rays which revealed a constricting mass at the level of the distal esophagus. Surgical excision of a 4 x 6 cm left labial mass was performed. Esophagoscopy and dilatation of the distal esophagus were performed concluding with a diagnosis of achalasia. Microscopic examination of the labial mass revealed cellular benign leiomyoma (Figure 2).

Dr. Barricks was a resident in the Department of Obstetrics and Gynecology at The University of Iowa College of Medicine when this paper was prepared. He is now in the U. S. Air Force, serving in the Obstetrics-Gynecology Service at the Ehrling Bergquist USAF Regional Hospital (Strategic Air Command), Offutt Air Force Base, Nebraska.

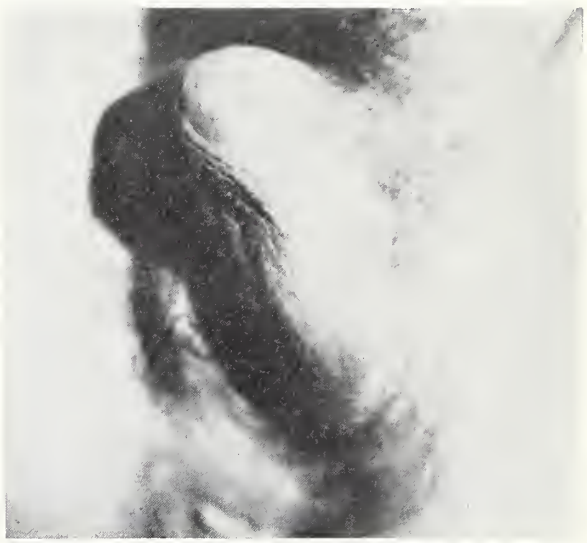


Figure 1. Large left labial lesion.

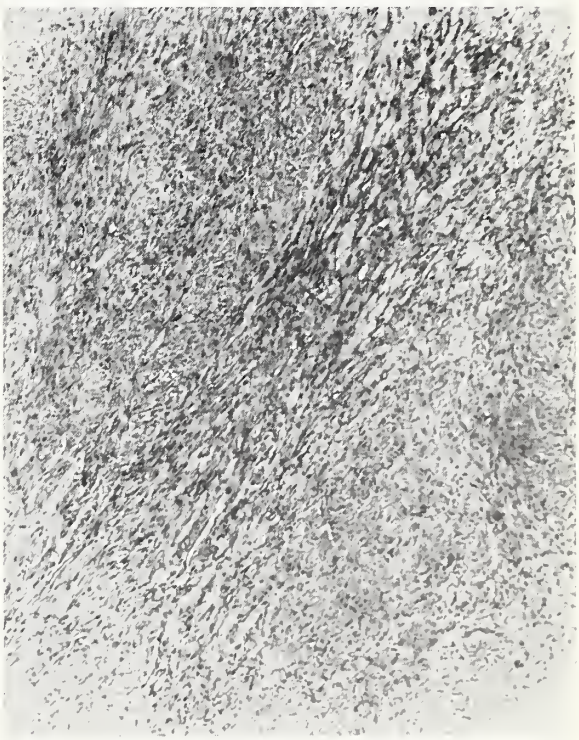


Figure 2. High power microscopic pictures of mass in Figure 1. Diagnosis was cellular benign leiomyoma.



Figure 3. Clinical appearance of clitoral hypertrophy.

The patient did well until 1968 when she underwent an exploratory laparotomy for pelvic pain. Bilateral ovarian endometriosis was diagnosed and confirmed by examination of tissue obtained from wedge resection of each ovary. The abdominal and pelvic findings were normal. An incidental finding during this evaluation was a soft, non-tender but markedly enlarged clitoris. She was again asymptomatic but in mid-1970 she sought evaluation of the clitoral enlargement and was then referred to

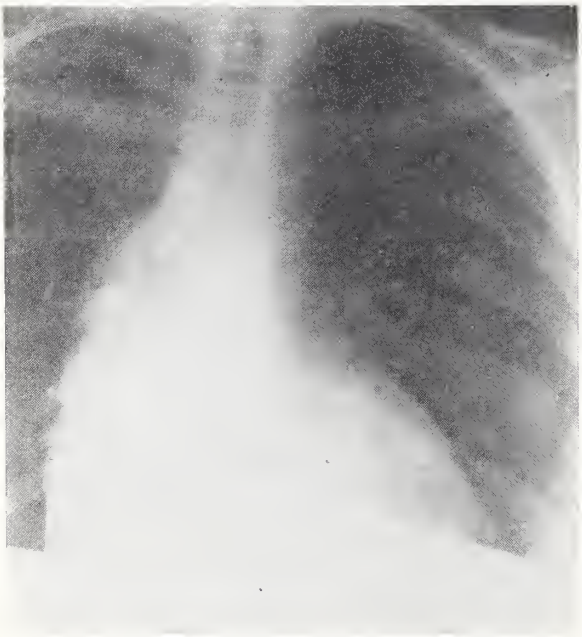


Figure 4. Routine PA chest x-ray showing mediastinal mass.

The University of Iowa Hospitals. At this time, she had no further symptoms of endocrine dysfunction. Her only other complaint was dysphagia.

Physical examination revealed a slightly obese Caucasian female in no distress. She was 5 feet tall and weighed 140 pounds. Her initial blood pressure was 120/80 and pulse rate was 72 beats per minute. No webbing of the neck or other abnormality was noted in the physical examination. There was minimal hair growth above the upper lip, occasional breast hair, and a female escutcheon. Pelvic



Figure 5. Upper G.I. picture of a huge mass with dilated proximal esophagus, thickened esophageal wall, and involvement of distal esophagus and proximal stomach.

examination revealed a markedly enlarged clitoris, measuring 3 x 3 cm at its base (Figure 3). It was a soft consistency and not nodular or tender. The labia revealed a small nodule in the superior aspect of the right labium majora. The external urethral meatus was slightly more proximal and inferior than normal. There was a 3 cm wide, smooth, firm area along the anterior vaginal wall from just proximal to the urethral meatus to the area of the urethrovesicle angle. The vagina was otherwise normal, as was the cervix. The uter-



Figure 6. Surgical specimen removed from the patient. Esophagus above and proximal portion of stomach below.



Figure 7. Opened specimen from Figure 6.

us was difficult to outline, but was thought to be slightly enlarged and somewhat irregular. Neither ovary could be definitely palpated, but the adnexal areas were free of significant masses. Rectovaginal examination confirmed the above findings. Laboratory examinations revealed a normal CBC and urine analysis. Buccal smear was chromatin positive. Chest x-ray revealed a huge mediastinal mass (Figure 4) and follow up upper G.I. x-rays, esophagoscopy and ultrasound confirmed the presence of an extramucosal mass from the proximal esophagus distally and involving the stomach (Figure 5). 17-ketosteroid levels were normal at 7.8 mgms/24 hours and 7.5 mgms/gram of creatinine. Plasma androgen levels were within normal limits. A bone marrow study was also normal. Careful discussion with the patient and her family revealed no other female member of the family with clitoral hypertrophy or known endocrine dysfunction. Her mother recalled no medications taken during the patient's gestation. No other family member has known leiomyoma.

The abdomen was explored through a left thoraco-abdominal incision. A large gastric mass measuring 92 cms in length was found. Involvement began in the esophagus above the aortic arch and extended the length of the esophagus to include the proximal 10 cms of the stomach (Figures 6 & 7). The specimen weighed 1570 gm and the wall of the esophagus varied in width from 0.5 to 3 cms. A 60% gastric resection and total esophagectomy were performed, and the proximal portion of the stomach was anastomosed to the distal oral pharynx. At the time of surgery, the bowel and upper abdominal organs felt normal. There were two small nodules felt on the serosal aspect of the uterus, and these were thought to represent small leiomyomata. The patient's post-operative course was uneventful.

During a routine post-operative examina-

tion two months after her thoraco-abdominal procedure, the patient related symptoms of urinary retention. Pelvic examination revealed a lesion in the anterior vaginal wall that was greatly enlarged when compared to the original evaluation. The mass was 6-7 cm in diameter and in the area of the urethrovesical angle. The cervix and uterus were elevated out of the pelvis by this mass. Cystoscopy and radiographic evidence of a bladder tumor led to a repeat laparotomy. A partially resectable leiomyoma of the bladder wall was found. Subsequent careful evaluation of the microscopic appearance of the esophageal, gastric, and bladder tumors revealed their microscopic findings identical to those of the benign vulvar leiomyoma in Figure 2.

DISCUSSION

When considered separately, clitoral hypertrophy (especially idiopathic), vulvar leiomyoma and esophageal leiomyoma are in themselves rare lesions. This combination of findings has been reported by Wählen and Åstedt[1] from Sweden. In their report, this same triad was found in a mother and her daughter with similar normal endocrine findings. The case described makes the third where multiple leiomyomata have been found in these two sites, i.e., esophagus and vulva. In addition, idiopathic clitoral hypertrophy has been an associated finding. The finding of a vulvar leiomyoma without clitoral enlargement is usually of diagnostic interest after removal of a mass. Review of the American literature shows 32 cases have been reported thus far. Palermino reported one case and reviewed 20 others.[2] Folsome[3] and Lovelady[4] reported the remaining 11. No clitoral hypertrophy or other leiomyomata were found in any of these cases.

The problem of explaining the etiology of clitoral hypertrophy in a patient with a positive buccal smear, normal physical appearance, normal development, normal menstrual history, normal 17-ketosteroid and androgen levels, negative history for exposure to exogenous hormones, and negative history for maternal exposure to hormones during the patient's gestation is most difficult. The patient also denies masturbation or other clitoral stimulation. The possibility of selective virilization of the clitoris without other evidence of hirsutism or virilism is remote. The softness and lack of nodularity rules out a leiomyoma in this area on clinical grounds. A disruption or alteration of the blood supply secondary to the previously described tumors is a possibility. With the exception of the remote consideration of an arteriovenous malformation or other vascular problem, the clitoral hypertrophy in this patient must be considered "idiopathic" at this time.

Available data from The University of Iowa Hospitals dating back to 1932 likewise shows the rarity of vulvar leiomyoma. Previous reports suggest fibromas, lipomas and hemangiomas are the most common benign vulvar lesions. Our data is as follows:

TABLE I

INCIDENCE OF BENIGN LESIONS SINCE 1932

Lesion	Number of Cases
Inclusion cyst	8
Nonspecific inflammation	5
Hydradenoma	4
Papilloma	3
Lipoma	3
Pigmented nevus	3
Leiomyoma (includes present case)	2
Hemangioma	2
Paget's disease	1
Total	31

We have reported the thirty-third case of a benign vulvar leiomyoma. However, it is the third case reported where benign leiomyomata have been found on the vulva and in the esophagus. Of particular interest is the finding of idiopathic clitoral hypertrophy as an incidental lesion. In all three cases, endocrine evaluation revealed no demonstrable abnormalities. The cytologic evaluation of our material, as well as that of Wählen and Åstedt, confirms the benign appearance of these lesions with no evidence of malignancy. Extirpation of the masses was warranted in the cases and involved major surgical procedures. Finding a vulvar leiomyoma justifies a complete and thorough investigative workup including gastro-intestinal and urinary tract evaluation.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

DON'T UNDERESTIMATE THEM

I have given several lectures during the past two months to second year students at the College of Osteopathic Medicine and Surgery. After the lectures, as is customary, 3 or 4 students come forward to ask questions or make comments. The questions presented were nearly always of high caliber and often beyond the scope of the subject under discussion. My curiosity was aroused about the academic background of these students.

There were about 150 students in the group; only one did not possess a college degree. There were two who had attained the doctor of philosophy degree (pharmacy; pharmacology), and one was in the process of completing his Ph.D. thesis (physiology). Thirteen of the students held master's degrees, in such subjects as pharmacy, pharmacology, public health, molecular genetics, biochemistry, microbiology, sociology, occupational health and analytical chemistry.

How does this compare with the students at the University of Iowa College of Medicine? There are 165 students in the current second year class. Twenty of them completed some graduate work before entering medical school. Eight have a master's degree; two have the Ph.D. degree. Six have no college degrees. Thus, the comparison between the two schools is very similar.

These are intelligent men and women. Their academic abilities have been established. They strongly desire to be physicians. Many were not able to enter medical school upon first application for any number of reasons, but mainly because of the high number of applications and the relatively small number of places available. Their zeal is obvious—they have continued their educational pursuits until the opportunity to enter the study of medicine became available. Medicine has become their life. They are involved in the life sciences, and now desire to know the art of medicine. Do not underestimate their abilities and their capabilities for the future.—M.E.A.

THE GATHERING STORM

This foreboding title introduced Sir Winston Churchill's eloquent memoirs of World War II. A similar ominous portent might be read into the clouds piling up on the medical horizon in this country. Flashes of political lightning and the rumbling thunder of consumerism shake the house of medicine. Winds of controversy rip at the AMA's "umbrella" concept for organized medicine.

Meteorologic metaphors aside, American physicians reared and trained in the one-to-one relationship for delivery of medical care now find themselves in a social milieu where four out of five workers have some form of health insurance, subject to one type or another of governmental regulation. It is estimated that more than a third of financial transactions between provider and recipient of health care services now involve government.

The recipient of health care used to be a "patient"; now he is a "consumer." In his name, increasing demands are being made for

non-physician representation on governing boards and on licensing bodies. The concept is not particularly new. More than 60 years ago, the Flexner report on American medical education said: "The physician is a social instrument. . . . Practically, the medical school is a public service corporation. It . . . cannot then escape social criticism and regulation."

There are advocates of change in health care delivery mechanisms, both within and outside the medical profession, who see an obvious analogy in the current controversies.

In medicine, as in nuclear physics and ecology, man's technical achievements have outpaced his sociological and humanitarian accomplishments. Have they also outpaced his ability to finance and deliver these achievements for the benefit of the "consumer"? Third parties are asking physicians to tread the stony path of cost control with eyes firmly fixed aloft on the star of quality care. Some toes are going to be stubbed.

In pre-paid, capitation plans for medical care, cost control is the primary selling point. The discriminatory singling out of physicians' fees under the Economic Stabilization Program had similar motivation. And now PSRO, already enacted into law, is about to materialize like Banquo's ghost out of the pages of the Federal Register.

"The emerging HEW emphasis under Public Law 92-603 is cost containment," says the HEALTH LETTER of the Health Planning Council of Central Iowa in reporting an article by Lawrence Newell, executive director of the American Association of Comprehensive Planning.

"Some believe that PSRO's will help hold the line on utilization," admits Dr. Charles Edwards, former Iowan, now HEW's assistant secretary for health. "But the chief benefit from PSRO's will be their role in quality control. . . . It isn't easy to build all of the variables into an acceptable review system. In my opinion, we have a long, long way to go."

Among physicians, there is a total spectrum of reaction to going that long, long way. The militant opponents will have none of it; the bulk of the profession will go more or less reluctantly; the more rabid "liberals," relatively few in number, believe it is the path to the end of the rainbow.

It does not serve the interests of physician, planner, or patient to insulate themselves from one another, nor to discuss problems as less than men of goodwill. On September 8, last, an areawide health planning conference was held at the Des Moines Area Community College, sponsored by the Health Planning Council of Central Iowa. Not one physician appeared on the six hour program!—HERMAN J. SMITH, M.D., *Des Moines*

SCREENING EXAMINATIONS REVISITED

It is gratifying to know my editorial comments are being read. Last month I commented on the Title XIX Medical Assistance screening program for those under 21 years of age. Since then I have had opportunity to discuss this program with several individuals in the State Department of Social Services (SDSS). Apparently it is necessary to engage in an exercise in semantics to clear the air. The definition of *screening* is "a system of *examining* and separating into different groups," while the definition of *physical examination* includes the four cardinal principles—inspection, palpation, auscultation and percussion in order to make a diagnosis. The diagnosis may show the patient is in a good state of health, or indicate the deficiencies or disease present.

Apparently, in many areas of the United States, "screening examinations" are done by nurses or medical assistants. This is due to the lack of physicians or to the actual design of the governmental programs. In these areas complete physical examinations, in our medical meaning of the term, cannot be done. In Iowa the provision of screening services by public health nurses has been approved by the county medical society in 15 counties. In additional

counties plans are under way for orientation courses for public health nurses to work with the State Department of Health in the same endeavor.

The primary purpose of screening is to separate well children from those with impairments or defects. Those with defects are to be referred for further diagnosis and/or treatment. Statistics from the SDSS show 10,000 children were "screened" in Iowa in the year ending July 1, 1973, and 16% of these children were referred elsewhere. Data does not indicate the percentage of these children screened by physicians or public health nurses. It is conceivable many who were referred could have been cared for by the "screening" physician at the time of the examination, with a resultant decrease in total cost.

Now back to the semantics. In Des Moines all children entering kindergarten, 4th, 7th and 10th grades are "required" to have complete physical examinations. Therefore, those children under Title XIX must be "examined," not "screened," though the definition for "screening" includes the word "examined." However, the amount of compensation to the examining physician is different for an examination as opposed to a screening. Under the circumstances, I cannot see much difference between the two procedures other than the possible situation wherein the professional status of the examiner is considered. When a physician does the procedure it constitutes a complete physical examination; when done by a paramedical person it might be called a screening procedure. What do you think? —M.E.A.

DESCRIBES TB CLINIC

Chemotherapy has eliminated or reduced hospital stays for tuberculosis patients. As a result, a need has developed for adequate outpatient facilities to assure treatment, follow-up, and surveillance of contacts. In response to this need, local tuberculosis outpatient clinics have developed.

The Waterloo Tuberculosis Clinic has been located in the outpatient department of St. Francis Hospital since 1969, and serves a 10 county area. Funding is provided by the Iowa State Department of Health, and services are offered to the patients at no cost other than the taxes they pay.

The object of this clinic is to assist physicians in the care of patients who may have mycobacterial infections. Staff includes a family physician with an interest in chest diseases and some additional training in mycobacterial infections, a full-time paramedical assistant and a part-time public health nurse with experience in tuberculosis. Services include medical consultation; x-rays; skin testing; sputum studies via the State Hygienic Laboratory; monitoring for drug toxicity (other than audiograms, which are done by the visiting nurses at patient expense), and all chemotherapy except for Rifampin which must be purchased locally by the patient, if prescribed.

The Waterloo Clinic has available the consultative support of the State Sanatorium at Oakdale, University Hospitals in Iowa City and the State Department of Health. Further assistance, e.g., supplies for the educational program for patients, nurses and student nurses, is provided by the Iowa Lung Association. The Clinic is open five days a week for paramedical consultation. Skin testing is done twice monthly with follow-up, with the physician present, two afternoons per month.

The Clinic has had 3,215 visits from 1,638 individual patients. Patients have seen the physician on 1,384 occasions and paramedical personnel in 1,831 visits. Non-tuberculous problems were seen in 104 patients with appropriate referral either back to the private physician or, upon his request, to the State Sanatorium or University Hospitals. Approximately one third of the patients were referred from their family physicians and the others were from Oakdale, Mayo Clinic, National Jewish Hospital in Denver and out-of-state sanatoriums.

Thirty-four patients with active pulmonary tuberculosis have been treated. Ten of these patients were treated entirely as outpatients, and 10 were treated after hospital stays of less

than two weeks. Fourteen active cases were referred to Oakdale. The age range of these patients has been as expected, with 0 to 3 years having 1 case; 3 to 12 having 2; 12 to 25 having 9; 25 to 45 having 9; 45 to 65 had 8; and there were 3 over 65.

Thirteen were seen with extra pulmonary tuberculosis to include 4 renal, 3 lymph node, 2 skeletal, 2 meningeal, 1 miliary and 1 tuberculosis epididymitis. Eleven patients were seen with atypical mycobacterial infections, all of which were pulmonary except for one widespread mycobacteriosis of the bone caused by Runyon Group III, Battey. To date the only death of a clinic patient attributable to mycobacterial infection was caused by Group III terrae comp (also Gaffky V, group I).

Forty-six patients have been dismissed from routine recall after having been disease free for three to five years after adequate chemotherapy, and in some cases INH prophylaxis was prescribed for those with old inactive disease who have never received chemotherapy.

Patient acceptance of the clinic has been adequate and is reflected in a low missed appointment rate. To date only two cases have been lost to follow-up, when they moved out-of-state and could not be located. There have been no known instances of patients refusing medication in the active cases, and few in the high risk positive reactors to the intermediate Mantoux. The low risk positive reactors (143) were placed on INH and 60 completed less than six months of medication, and 9 took approximately 9 months of prophylaxis. This has caused us to re-evaluate our use of INH in the low risk reactors. Drug reactions caused a change or cessation of therapy in 12 patients.

The clinic has enjoyed the support of the local medical community and interested local organizations. It would appear from this experience outpatient tuberculosis clinics can offer adequate services to Iowans with mycobacterial infections.—RONALD R. ROTH, M.D., *Clinician, Waterloo Tuberculosis Clinic*

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The Question Box



by NORMAN L. PAWLEWSKI

Norman L. Pawlewski was named Iowa Commissioner of Health in August. He has served in the Department of Health since 1965.

You are the first non-physician to serve as Iowa Commissioner of Health. Will this present you any special problems?

Not any that cannot be resolved. We have trained, licensed physicians on our staff who can counsel me on those medical problems that the Department must solve or respond to. I have also been assured assistance from private practitioners, University medical staff, the Public Health Service and the Iowa Medical Society. In my present capacity, I don't really need to have the medical expertise. I only have to know where it is and how and when to call on it for assistance.

You have been associated with the Department of Health for several years. In what capacities?

I have been with the Department of Health for eight years. I was assigned here by the U. S. Public Health Service as coordinator of the Immunization Program which is a section of the Preventive Medical Service. I gradually assumed more administrative responsibility within the Preventive Medical Service until I was named Deputy Chief under Dr. Hendricks, who is presently Chief of that Service. Three years ago I resigned from my position with the Public Health Service and accepted appointment as Assistant to the Commissioner, a position I held until July 1 of this year.

Are there special areas which will receive priority attention from the Department in your early months as Commissioner?

There are a number of areas which will receive priority attention from the Department, not only in my early months as Commissioner but throughout my tenure. These are the establishment and promotion of local health departments; providing quality health care services throughout Iowa, but in particular the rural areas; more involvement in health care services to the aged; the upgrading of health care facilities; maintaining Iowa immunization levels; controlling communicable diseases; improving maternal and child health care services and the many other programs which we are now involved in to some degree. One area that will receive priority attention from me in my early months is the strengthening and updating of the Department's internal organization and workings. We will become increasingly involved in staff development and training, the application of new management techniques and hardware and the improvement of communications within as well as to and from our Department.

Will the Board of Health continue to function much as it has while you are Commissioner?

No, it will not. It will take a more active role in determining the policies and the directions of this Department. The Board has already expressed a desire to become more involved in the Department's present operations and its future. I think the Board is willing to accept a greater responsibility for directing this Department's activities and the degree of influence those activities have on health in Iowa. I welcome their involvement and participation in what I foresee as a more aggressive, responsive and creative Department of Health.

Do you have brief comments as to the relations which you desire to foster with Iowa physicians as Commissioner of Health?

This Department not only desires but needs the support of Iowa physicians. It will be my

(Please turn to page 544)

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

"KNOWLEDGE DOES NOT KEEP ANY BETTER THAN FISH"

The colorful statement above is from Alfred North Whitehead, a British philosopher who must have known better. But then, its meaning depends on the context and the adjectives you wish to add to the sentence by implication. For example, by thinking of "smoked fish" you create a tolerable longevity for much knowledge.

Certainly those of us who are functioning professionals indeed have an incredible storehouse of information in our brains, even if we weren't "Quiz Kids" in an older day, or "Trivia Champions" in the recent jargon. Our memories are surely impressive by most standards. But is the remembering of information the same thing as knowledge? Maybe that's what Whitehead is getting at. More important than storage of information, which perhaps becomes as unsuitable for use as old fish, is our ability to reason—to note relationships, to interpret bits of data, to synthesize fragments into a sensible whole, to test possibilities—in sum, to solve problems. Whatever intellectual competencies (neurologic phenomena) are involved in problem solving, they are surely other than just remembering individual tidbits of fact.

If it be true that the half-life of medical information is about 7 years, then any physician at age 46 can appropriately use only about ⅛ of what he so painstakingly learned during medical school. And the 21 years since graduation need to have been filled with faithful exercise and polishing of the problem-solving skills.

But to expand Whitehead's word "knowledge" probably beyond his intention, there is yet another dimension of it we would wish for physicians. In the mature and ideal physician the information, the problem-solving, the service he provides are also augmented by wisdom and compassion. Where can one enroll in the short course that offers an increase in wisdom and compassion? No university offers such a course; the events of daily life create the workshop for developing wisdom and compassion. They grow from one's sum of experiences, with early experiences being especially telling. We think we can recognize wisdom and compassion even if we can't readily teach them. And I venture that once developed, *their* keeping power is good—if not like fossil fish, then at least like frozen fish.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

THE QUESTION BOX

(Continued from page 543)

job as Commissioner to establish, earn and maintain their support. I would like to get private practitioners more involved in public health and will seek ways to make this happen. Health, defined by the World Health Organization as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and Public Health, "the science and art of preventing disease, prolonging life, promoting physical and mental efficiency through organized community effort," are the responsibility of all of us working in public or private medical care, regardless of discipline.

REQUEST CONTINUING EDUCATION PLANS

A HOT TOPIC of the day in many circles is continuing education. *What kind? How much? Voluntary? Compulsory?* It is a many-faceted and important proposition. Obviously, it deserves thoughtful consideration by the various concerned segments of society.

The state's lawmakers directed their attention to continuing education during the 1973 session of the 65th Iowa General Assembly. Both the House and Senate approved the following resolution:

"WHEREAS, Most professions and occupations for which examining boards have been established require the applicant to pass an examination testing his knowledge and skills required for the practice of the profession or occupation; and

"WHEREAS, new developments are constantly occurring to change and improve the practice of licensed professions and occupations; and

"WHEREAS, Requirements for renewal of a license or registration, except for nursing home administrators or optometrists, merely require filing of the proper form and payment of a renewal fee; and

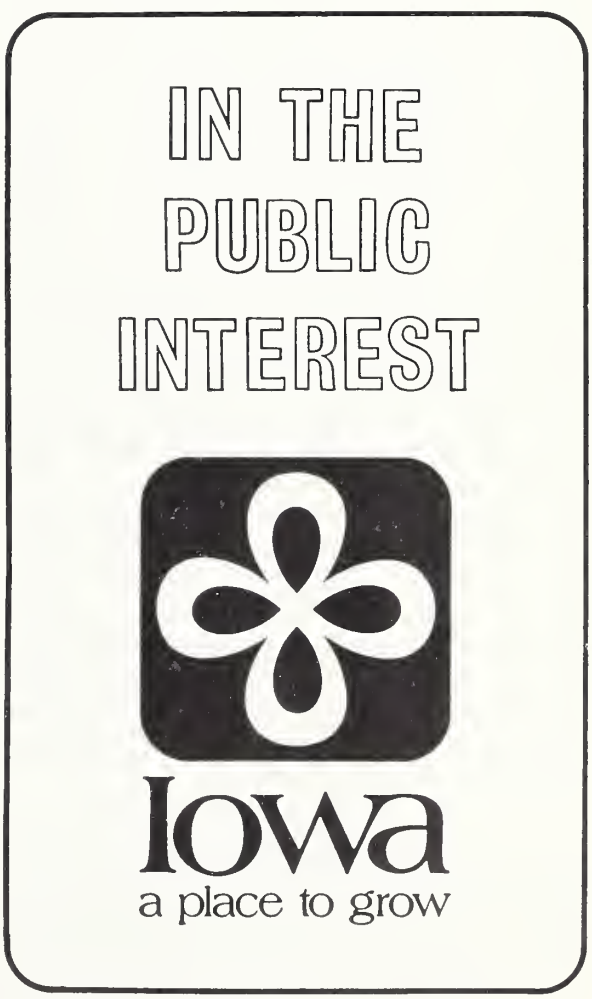
"WHEREAS, The Professional and Occupational Licensing Study Committee, established by the Legislative Council for the 1972 Interim, believes that each person licensed or registered by an examining board should be required to submit evidence of continuing education in order for his license or registration to be renewed, but the Study Committee also believes that each individual examining board can best determine what type of continuing education is most suitable for its occupation or profession, now therefore

"*Be It Resolved* by the House of Representatives, the Senate concurring, That each examining board be required to submit in writing to the General Assembly, no later than January 14, 1974, its recommendations for continuing education requirements for licensed or registered members of its occupation or profession."

MIXED IMPLICATIONS

This action by the Iowa legislature has mixed implications. It's good in that, obviously, each state examining board now has a challenging assignment. They must devise continuing education plans which their licensees or registrants may be required to follow if they desire to practice their profession or occupation. The resolution is questionable if the population concludes that it constitutes a "first" in the realm of continuing education. In various areas, and notably medicine, voluntary participation in continuing education has been a broad, long-standing and essential custom. This new governmental impetus appears to be national in scope.

In mid-October, at an important meeting of the policy-making Iowa Medical Society House of Delegates, the subject of continuing medical education received further consideration. (It has on numerous previous occasions.) The Society's Committee on Medical Education and Hospitals submitted a report which culminated with the physician-delegates approving the following resolution:



Resolved, That the importance and value of continuing medical education be totally and forcefully reaffirmed by the Iowa Medical Society; and be it further

Resolved, That the details of devising a program for documenting evidence of continuing medical education be considered jointly by the Iowa Medical Society, by the State Board of Medical Examiners and by the Iowa Society of Osteopathic Physicians and Surgeons; and be it finally

Resolved, That a progress report on the development of such a program be submitted, prior to the consideration of any state legislation, to either this House of Delegates or to the Executive Council.

EXAMINER ACTION

This action of the Iowa Medical Society followed on the heels of a motion approved by the State Board of Medical Examiners. The eight-member Board passed this motion October 10: "It is moved, seconded and carried that the Iowa State Board of Medical Examiners feels that documentation of continuing medical education should be a requirement for relicensure; and that the Board should work with the Iowa Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons, and appropriate committees of these societies, to seek enabling legislation dealing with such relicensure."

Thus, the mechanism for responding to the edict of the Iowa General Assembly has been established.

Through the years the Iowa Medical Society has encouraged, fostered and developed many scientific education opportunities for its member physicians. The Society's annual scientific sessions are structured to serve a wide base of physician interest. In addition to the Society's efforts, state specialty organizations, county medical societies and hospital medical staffs arrange a myriad of scientific programs during the course of a year. Involved in much of this activity, in terms of support and expertise, is The University of Iowa College of Medicine.

PHYSICIAN SURVEY

In recent weeks the Office of Continuing Medical Education at The U. of I. College of Medicine and the Iowa Medical Society Committee on Medical Education and Hospitals have collaborated in a continuing medical education (CME) survey of Iowa physicians. A major, but not unexpected, finding of this survey is that Iowa physicians are currently devoting an extraordinary amount of time, effort and money in the process of their professional education. Analysis of the survey suggests that Iowa physician participation in various kinds of learning experiences may add to more than 350 hours per year, or approximately one full working day per week.

Reading the signs of the times, 71% of the Iowa physicians surveyed expressed the belief that continuing medical education as a "requirement" is forthcoming.

The major concern in this "requirement" consideration, as the survey summary* points out, is that "not all forms of continuing medical education are externally 'documentable.'"

WHAT'S DOCUMENTABLE

The summary declares that, "Among those certifiable as to presence or enrollment of the physician are hospital conferences, post-graduate lectures, symposia, and courses sponsored by various organizations, home study courses and self-assessment examinations. How does one 'document' the valuable and considerable learning that may accrue via reading, colleague consultation, audio-tapes, teaching, research, writing, or other innovative methods that are highly individual and private? And of course, how does one find the formula to relate 'spends time' to 'learn' to 'changes behavior' to 'improves health care given'?"

The summary continues, "That 71% of the sampled physicians expect soon some sort of continuing education requirement, is surely an important finding. If that expectation materializes, then the profession will face an increasing challenge to assure for itself high-quality educational experiences that respond to locally identified needs, plus a satisfactory method of accrediting or documenting each physician's attainment in a manner that will satisfy the profession and those outside it who are clamoring for the evidence of highest quality health care. A carefully structured effort, developed collaboratively with all elements of the medical profession, will be required to achieve such a goal."

Aptly stated. Hopefully, the pace will be deliberate, not in the nature of a stampede.

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* SURVEY OF CONTINUING MEDICAL EDUCATION IN IOWA—MEMBERS OF THE IOWA MEDICAL SOCIETY, 1973, Richard M. Caplan, M.D., and Thomas Yarcheski, B.A.

Doctor's Business

by LARRY E. LEAVERTON

WHAT MAKES AN OFFICE EFFICIENT?

We are often asked, because of increased costs and limitations on fee increases, how can my office become more efficient? How can I save time and increase production without sacrificing quality? The modern medical office must be efficient to handle these increased costs and the increasing demand for medical care.

The efficient and well managed medical office will have most of the following attributes:

1. The office will be well located—convenient to patients and to the doctors. Commuting time from office to hospital and residence to office should be at a minimum.

2. The layout will be keyed to production with an adequate number of examining rooms arranged to allow a smooth flow of traffic.

3. The efficient office will have well trained medical assistants in adequate number. They will be carefully selected, well paid, and expert in handling patients. How many medical assistants are necessary in a well managed office? A recent survey of approximately 1,000 offices disclosed an average of 2.4 medical assistants per physician. There was a range from 2.8 in general practice to 2.1 in the surgical specialties.

4. There will be clear, written policy on personnel and administrative procedures dealing with fees, discounts and emergencies. These procedures will be adapted to the particular style of practice. These policies should be flexible. Just because something has always been one way it should not prohibit a change. Having policies in writing helps to prevent misunderstandings.

5. The efficient physician will delegate all duties he can to trained assistants so long as they do not detract from the quality of medical care and remain within ethical and legal limits. Why delegate? The time saved can provide more benefits to more patients, and add to the physician's own health and well being.

6. There will be modern medical equipment in all rooms—duplicating items where necessary so as to not tie up a room during peak periods.

7. Modern timesaving business equipment will be in evidence—electric typewriters, billing equipment, dictating equipment, copy machine, telephone systems and intercoms. You can't expect top production without the best tools.

8. An efficient billing system with provision for prompt follow-up of delinquent accounts.

9. Modern and efficient forms and systems for their use—orderly case histories, new patient information, routing slips, instructions to patients, and forms to facilitate prompt preparation of insurance and other third party claims.

10. Good public relations—with patients, colleagues and the community. When offices become extremely busy it is easy to forget common courtesies.

11. An appointment system that provides the flexibility necessary to handle a busy schedule. This system should give proper allotment of time and emergency time as needed according to type of practice and past experience.

12. Finally, the efficient well managed office will have sources of assistance and advice on both medical and business problems.

An efficient and well managed practice not only provides more benefits for more patients but is also a more satisfying practice for the physician.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

About IOWA Physicians

Dr. Haiwood Kim, a native of Taegu, Korea, is new medical director of Lee County Mental Health Center. Dr. Kim interned at Kuakini Hospital in Honolulu and had a psychiatric residency at Independence Mental Health Institute. Prior to his new appointment, Dr. Kim served as staff psychiatrist at Mt. Pleasant MHI. . . . **Dr. J. M. Rhodes, Sr.,** Pocahontas, is seeking re-election to Pocahontas Community School Board. Dr. Rhodes has served as board member for several terms. He was also recently re-elected to fourth term on the Blue Shield of Iowa Board of Directors. . . . At recent meeting of Cedar County Health Council, **Dr. L. Robert Martin,** director, Cedar Rapids Medical Education Program, described work being done at new satellite office in Mechanicsville which is part of C.R. Family Practice Residency Program. . . . **Dr. William M. Bourne,** resident physician in U. of I. Department of Ophthalmology, has been awarded a $4,000 research grant to investigate the viability of cells in frozen donor material for corneal transplants.

Dr. Jack N. Morgan, Fairfield, was main speaker at Fairfield seminar sponsored by the National Ambulance and Medical Services Association. Dr. Morgan's topic: "You and the General Practitioner." . . . **Dr. James R. McKlveen** has joined the McFarland Clinic in Ames. A native of Prairie City, Dr. McKlveen received the M.D. degree from Baylor University. He interned at Hennepin County General Hospital in Minneapolis, Minnesota and completed a residency in anesthesiology at University Hospitals in Iowa City. Dr. McKlveen has just completed two years in the U. S. Navy. . . . **Dr. J. V. Belsare,** Mt. Pleasant surgeon, was recently named a member of associate medical staff at Washington County Hospital. . . . **Dr. Wayne L. Severson,** medical director of Blue Cross and Blue Shield of Iowa, is new member of the medical advisory committee of the National Association of Blue Shield Plans. Dr. Severson is first Blue Shield of Iowa representative named to this committee. He will join medical officers from six other Blue Shield plans to formulate and recommend NABSP medical policies.

Drs. C. Robert Osborn and **Keith M. Chapler,** Dexter, were recently honored for their 40 years of community service. During recognition program plaques were presented to the two physicians. Elaborate picture display of babies delivered by Drs. Osborn and Chapler was part of recognition program. . . . **Dr. Fred G. Smith, Jr.** is new professor and chairman of Department of Pediatrics at U. of I. College of Medicine. Dr. Smith succeeds **Dr. Donal Dunphy** who continues as professor of pediatrics. Dr. Smith was professor of pediatrics and chief of the Division of Nephrology at University of California. . . . **Donald L. Taylor,** Executive Vice President, Iowa Medical Society, was re-elected secretary-treasurer of Iowa Health Council at recent IHC meeting. . . . **Dr. Philip Bakody, D.O.,** was "hooded" by his father, **Dr. John Bakody,** Des Moines neurosurgeon, at recent graduation ceremony at College of Osteopathic Medicine and Surgery in Des Moines.

Dr. L. F. Parker, head of Family Practice Residency Program at Broadlawns Polk County Hospital in Des Moines, was guest speaker at recent meeting of Health Planning Assembly of Hardin County. Dr. Parker discussed a study of hospital needs in Des Moines which proposes that Broadlawns be converted to psychiatric hospital. . . . **Dr. Curtis C. Fredrickson**

recently opened an office in Iowa City to practice psychiatry. Dr. Fredrickson received the M.D. degree at U. of I. College of Medicine; interned at Sioux Valley Hospital, Sioux Falls, South Dakota and completed his psychiatric residency at Psychopathic Hospital in Iowa City. . . . **Dr. Philip J. Sullivan,** formerly of Overland Park, Kansas, has joined the Leon Clinic. A graduate of U. of I. College of Medicine, Dr. Sullivan completed his internship and residency in orthopedics at Kansas City General Hospital, Kansas City, Kansas. . . . **Dr. B. A. DeLeon, Jr.,** is new medical director of West Central Mental Health Center in Adel. Dr. DeLeon was formerly a staff member at Clarinda Mental Health Institute and served WCMHC on a part-time basis. Dr. DeLeon will work toward establishment of satellite offices at Dallas, Madison and Guthrie County Hospitals.

Dr. and Mrs. Ralph Gorrell, Clarion, attended twenty-fifth anniversary of Iowa Academy of Family Physicians in Des Moines. Dr. Gorrell is a charter member of the original founding group of 13 physicians. . . . **Dr. Kie Yun Lee** has joined **Drs. Bill Withers** and **Clark Rominger** in Waukon. Dr. Lee received his medical training in Korea and interned in Albany, New York. Prior to locating in Waukon, Dr. Lee was a surgeon at Veterans Hospital in Des Moines for seven years.

Dr. J. G. Donovan, Carroll, has been named the community's 1973 United Way campaign chairman. Dr. Donovan is past president of the Chamber of Commerce, recipient of the 1972 Citizen of the Year Award, past president of Rotary, past president of St. Lawrence School Board and immediate past president of Kuemper Parents Club. . . . **Dr. John S. Thompson,** chief of medicine at VA Hospital in Iowa City and vice-chairman of Department of Internal Medicine at U. of I. College of Medicine, has been awarded a three-year $140,000 research grant from the National Cancer Institute. Under the grant Dr. Thompson will seek to isolate a substance in the blood of the unborn fetus and in experimental and human liver tumors which may immobilize the normal immune defense mechanisms.

Dr. Josefina L. Hizon has joined **Dr. L. K. Berryhill** in the private practice of psychiatry in Fort Dodge. Dr. Hizon also has been appointed assistant medical director of the North Central Iowa Mental Health Center. A board eligible psychiatrist with training in general psychiatry and additional specialization in geriatrics, Dr. Hizon received the M.D. degree at Far Eastern University in the Philippines, interned at Deaconess Hospital in Milwaukee, Wisconsin, and served a residency in psychiatry at the Mental Health Institutes in Cherokee and Independence. . . . **Dr. Jon Wubbena,** Rock Rapids, has been appointed to complete the remaining term of office vacated by the late **Dr. S. A. Cook** on the Commission of Mental Health in Lyon County. . . . **Dr. R. L. Knipfer,** former Jesup physician, now residing in Woodland Hills, California, attended the annual meeting of the Iowa Chapter, American Academy of General Practitioners in Des Moines. Dr. Knipfer was one of the founders of the Iowa Chapter and served as Academy president in 1958. Past presidents of the organization were honored. . . . **Dr. George N. Bedell,** professor of internal medicine, and **Dr. Charles A. deProsse,** assistant professor of obstetrics and gynecology, both at U. of I. College of Medicine, were guest speakers at the annual scientific meeting co-sponsored by the Page County Medical Society and the College of Medicine. **Dr. Najed Chaarani,** Shenandoah, and Dr. Hans Frenkel, Clarinda, served as moderators for the program held in Shenandoah. Physicians from southeast Nebraska, northwest Missouri and 13 southwest Iowa counties attended.

During recent pediatrics continuing education conference at U. of I. College of Medicine, **Dr. Donal Dunphy,** U. of I. professor of pediatrics, was honored at a testimonial dinner. Dr. Dunphy served as chairman of the Pediatrics Department from 1961 to 1973. . . . **Dr. Peder Madsen** has joined the medical staff of the Newton Clinic. A native of Denmark, Dr. Madsen received the M.D. degree at University of Copenhagen in 1948. He is a Swedish board certified surgeon and pediatric surgeon. Dr. Madsen came to United States in 1970 following his marriage to Mrs. Fred Maytag II, New-

ton, in 1969. In 1972 he attended a surgery clinic at U. of I. College of Medicine and interned for a year at Iowa Lutheran Hospital. . . . **Dr. Charles Hawkins,** Clarion, was installed as president of the Iowa Academy of Family Physicians at the group's twenty-fifth annual meeting in Des Moines. Other 1973-74 officers are: **Dr. F. M. Ashler,** Hamburg, president-elect; **Dr. J. H. Coddington,** Humboldt, vice-president; **Dr. George Kern,** Des Moines, secretary-treasurer; and **Drs. Verne Schlaser,** Des Moines and **Lee Rosebrook,** Ames delegate and alternate to the American Academy of Family Physicians. Elected to three-year terms on the board of directors were **Dr. Roger Boulden,** Lenox, and **Dr. Leslie Weber, Jr.,** Wapello.

Dr. Richard L. Sedlacek, Cedar Rapids, has been appointed to Linn County Health Center Board. Dr. Sedlacek was one of the founding board members and served as chairman in 1970. . . . **Dr. Lawrence Donovan,** Estherville, was guest speaker at recent meeting of Estherville Nurses Association. Dr. Donovan's topic: "Effects of Drugs on Long-Term Patients." . . . **Dr. Mohammed Badruddoja** joined the Clarke County Medical Clinic in Osceola October 1. Dr. Badruddoja received the M.D. degree at Dacca Medical College in Bangladesh, Pakistan and served a surgical residency at Highland Park General Hospital in Detroit, Michigan. He is a member of the American Board of Surgery, Fellow of the Royal College of Surgeons in Canada and member of the International College of Surgeons.

Dr. Andrew C. Smith, Waterloo, presented a program on "Stress Testing," at recent meeting of Black Hawk County Heart Unit, local volunteer organization of the Iowa Heart Association. . . . **Dr. E. E. Gingles,** Onawa, was honored September 1 at a reception in commemoration of his 40 years of medical service to the Onawa community. Dr. Gingles began his practice in Onawa September 1, 1933. He and Mrs. Gingles recently celebrated their 50th wedding anniversary. . . . **Dr. Donald Boyle,** Sioux City, discussed the future role of emergency medical technicians at an Emergency Medical Services Training Conference in Des Moines.

Physicians and their wives from throughout Iowa were guests of the Webster County Medical Society at a recent medical day in Fort Dodge. Speakers included—**Dr. M. E. Kraushaar,** Fort Dodge, who welcomed the group on behalf of the Webster County Medical Society; **Dr. Frederick K. Chapler,** associate professor of obstetrics and gynecology at U. of I. College of Medicine, and **Dr. Charles Coughlan,** Fort Dodge. . . . **Dr. Charles Bendixen,** Marshalltown, was guest speaker at monthly meeting of Marshalltown Engineers Club. Dr. Bendixen related some of his findings while conducting research on restraint systems in automobiles and aircraft. In addition to his M.D. degree, Dr. Bendixen has a degree in mechanical engineering and during Air Force Service was chief of biodynamics at Holloman Air Force Base, New Mexico. Decision to postpone until 1976 ruling by Transporation Department that all cars must be air bag equipped is result in part of the work done by Dr. Bendixen. . . . **Dr. Eugene L. Wiemers** has been appointed superintendent of the Cherokee Mental Health Institute. Since the retirement of **Dr. J. T. May** last April, Dr. Wiemers has been acting superintendent. He received the M.D. degree at University of Texas and before locating in Cherokee, served as a neuropsychiatrist in the U. S. Army Medical Corps and was assistant superintendent of Utah State Hospital. Dr. Wiemers is certified in psychiatry by American Board of Psychiatry and Neurology.

DEATHS

Dr. Allan B. Phillips, 63, a Des Moines radiologist, died September 11 at his home following an illness of several months. Dr. Phillips received the M.D. degree at Washington University School of Medicine and had practiced medicine in Des Moines since 1933. He was a former president of Polk County Medical Society, former secretary of Iowa Medical Society, past president of Iowa Radiological Society, former president and secretary of Medical Library Club of Des Moines, member of Iowa Medical Society and American Medical Association.

Dr. James H. Turner, 41, Fairfield, died September 8 in a car-train accident at Fairfield. A graduate of U. of I. College of Medicine, Dr. Turner served his internship at Mercy Hospital

in San Diego, California, and located in Fairfield in 1958. He was a past president of Jefferson County Medical Society; past chief of Jefferson County Hospital medical staff; diplomate of American Academy of Family Practice, member of Iowa Medical Society and American Medical Association.

Dr. Jerome F. Paulson, 58, Mason City orthopedic surgeon, died September 20 in one-car accident in west Mason City. Death was attributed to a heart attack. Dr. Paulson received the M.D. degree at University of Wisconsin College of Medicine; interned at Christ Hospital in Cincinnati, Ohio; and returned to University of Wisconsin College of Medicine to complete his residency in orthopedic surgery. Dr. Paulson served on Judicial Council of IMS and was a current member of the IMS Board of Trustees. He was a staff member of St. Joseph Mercy Hospital in Mason City; diplomate of American Board of Orthopedics; member of American and Midwest Orthopedic Associations, Cerro Gordo County Medical Society; Iowa Medical Society and American Medical Association.

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Medical Assistants

by TENORA MEYER, CMA

12 NEW CMA'S IN IOWA

A record number of 356 medical assistants have become Certified Medical Assistants by successfully passing the 1973 AAMA certification examination. This examination is given each June. These medical assistants received certificates and pins at the October 24 CMA dinner in their honor at the AAMA annual convention in Washington, D. C. The record total includes 118 who passed the Administrative examination, 132 who received Clinical certification, and 106 for both categories. In addition, 29 candidates were CMA's achieving certification in a second category. Of the group, there are 68 students and 49 medical assisting instructors. A total of 820 candidates were examined at 65 test centers across the United States, plus one in Canada. The Iowa CMA's are as follows:

Betty Ehlert, Des Moines, Administrative; Bernice Formella, Burlington, Administrative; Leanna Griffin, Lamont, Clinical; Donna Haney, Des Moines, Administrative-Clinical; Rosemary Herman, Des Moines, Administrative; Mary Hoye, Des Moines, Clinical; Marvel Lundeen, Akron, Administrative; Patricia Madsen, Council Bluffs, Administrative-Clinical; Wendy McDanel, Cedar Rapids, Clinical; Leanna Rist, Des Moines, Administrative; Patricia Skeesick, Cedar Rapids, Clinical, and Diana Vander Ploeg, Monroe, Administrative-Clinical.

AMES SEMINAR

Sixty-one Iowa medical assistants were in Ames September 29-30 for the Seminar sponsored by AAMA, State of Iowa. Sherry Chidester, Des Moines, was in charge, assisted by Charlotte Fell, Mary Hoye, Leanna Rist, Charlotte Lewis, Cynthia Keegan and Marcella Stiffenson.

Iowa President Sally Gesink, Sioux City, welcomed the group. An administrative secretarial review was led by Margaret Taylor, Des Moines Technical High School. An examination was given on grammar, punctuation, secretarial procedures and parliamentary law.

Dr. Michael Hirsch, Des Moines gynecologist, presented an illustrated program on "Laparoscopy—Female Sterilization."

Dr. Edward Hertko, Des Moines internist, described the Hertko Hollow Camp for diabetic children. The Camp has grown each year since 1968 and this past summer 120 diabetic children attended. It is held one week each summer at the Des Moines YMCA Camp on the Des Moines River near Boone. Dr. Hertko, several nurses, student nurses and medical students serve voluntarily during the period. Recreational activities include fishing, swimming, boating, crafts, riding, hiking, sports, etc., are available to the children. They are taught how to give insulin to themselves and how to cope with their disease and lead normal happy lives.

At the luncheon, the Des Moines Chapter presented a "style show skit" utilizing medical instruments and accessories in their garb.

Jeanne Green, Davenport, AAMA trustee, spoke at the luncheon on "Certification." She explained the purpose of certification and its advantages to medical assistants.

A film entitled "Pulse of Life" and showing the ABC's of cardiopulmonary resuscitation was presented. Jane Hasek, R.N. and Dr. Orrin Hall, Waterloo anesthesiologist, followed the film with a training program utilizing mannequins.

A clinical review was conducted by Shirley Muehlenthaler, R.N., Des Moines Area Community College, which included an examination on clinical aspects such as anatomy, physiology, laboratory, etc.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

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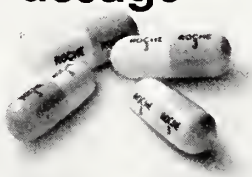
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which follows:

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Contraindications: Patients v hypersensitivity to the drug.

Warnings: Caution patients al combined effects with alcohol and ot depressants. As with all CNS-acting patients against hazardous occupatio complete mental alertness (*e.g.*, oper ery, driving). Though physical and p dependence have rarely been reporte mended doses, use caution in admini addiction-prone individuals or those increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

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Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

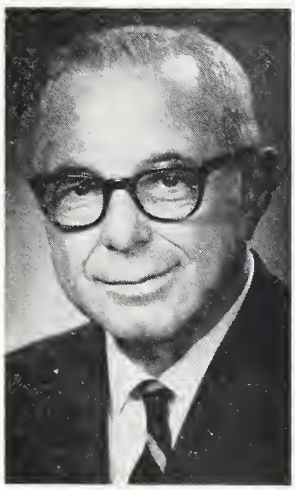
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page



Informed sources report the State of Iowa is to be designated a single PSRO (Professional Standards Review Organization) area. In fact, by the time the December JOURNAL reaches your desk the announcement may have been made. P.L. 92-603 requires the Department of Health, Education and Welfare to make area designations by the end of 1973.

This initial step (area designation) in the implementation of PSRO has been debated extensively. At issue is whether a state with practicing physicians beyond the 2,500 to 3,000 guideline should be permitted to have a single PSRO. The medical profession has urged flexibility, i.e., in larger states let there be an umbrella-type PSRO when this arrangement is acceptable to those involved.

A virtue, perhaps, of residing in a small- or medium-sized state, such as Iowa, is the absence of this type of problem. Should the Iowa Foundation for Medical Care become the Iowa PSRO, as your Society officers hope and as appears likely, it will rely heavily on its regionally organized peer review program and the good liaison it is evolving with hospital medical staffs.

Few IMS members look on PSRO with any relish. But because it has the force of law, there is comfort in knowing Iowa is up with and even ahead of the game. Please credit the leadership of the Society and Foundation for this ongoing surveillance in your behalf.

In closing out 1973 let me (1) extend best wishes for the holidays, and (2) thank you for receiving my November 7 letter inviting your membership renewal; it's things like PSRO that make your participation so important.

Season's greetings from your officers.

Sincerely,

Rubin Flocks, M.D.

Rubin Flocks, President

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IOWA Medical Miscellany

FEE RULING . . . Iowa physicians may increase fees 4% annually, provided the increase does not raise the profit margin. This ruling is part of the new price control regulations to become effective January 1. A fee for an individual service or procedure may be raised by as much as 10%, but a physician's aggregate weighted price increase must not exceed 4%. Compliance will be voluntary; AMA has persuaded the Cost of Living Council to shelve a compulsory monitoring program. Fees have been held to a 2.5% increase since December, 1971. AMA number to call for answers to special questions is 312/527-1571, Ext. 434.

PSRO . . . The State of Iowa is expected to be designated as a single PSRO area by the Department of Health, Education and Welfare this month. Area designations are to be determined by HEW by year's end. HEW is expected to sign agreements with about 50 PSRO's by April 30, 1974.

CHIROPRACTIC . . . First experimental study of "subluxation" has refuted the chiropractic theory. Edmund S. Crelin, Ph.D., professor of anatomy at Yale University, reports in September-October issue of AMERICAN SCIENTIST that subluxation of a vertebra, the theory on which chiropractic is based, "does not occur."

IMS DIRECTORY . . . Distribution of the Iowa Medical Society Membership Directory is in process. Copies are provided as a benefit of membership. IMS members are listed alphabetically and geographically.

CHRISTMAS SEALS . . . American Lung Association of Iowa (formerly Iowa Tuberculosis and Respiratory Disease Association) has its Christmas Seal program in full swing. Support is appreciated.

NEW IMS PROGRAM . . . New Blue Cross/Blue Shield group coverage for IMS members, families and employees has been approved and is now being explained to interested physicians. Program has a $250,000 major medical provision. To be implemented January 1, program is outgrowth of deliberations between IMS Group Insurance Committee and BC/BS officials.

PRESIDENT-ELECT . . . K. E. Lister, M.D., Ottumwa, is new president-elect of the North Central Medical Conference.

NATIONAL OFFICE . . . John MacQueen, M.D., Iowa City, is new vice-president and president-elect of the American Academy of Pediatrics.

FAMILY PRACTICE . . . New Iowa Family Practice Education Advisory Board, a requirement of recent state legislation, will include J. W. Eckstein, M.D., and R. E. Rakel, M.D., both of The U. of I.; Charles Ingersoll, Des Moines, administrator, Broadlawns Polk County Hospital; L. R. Martin, M.D., Cedar Rapids; R. L. Wicks, M.D., Boone; R. K. Simpson, D.O., Des Moines; L. W. Lawhorne, M.D., Iowa City; K. L. Clayton, D.O., Spirit Lake; and D. J. Ottilie, M.D., Oelwein.

LOAN PROGRAM . . . 42 Iowans are receiving medical student loans this fall from the Scanlon Medical Foundation/Iowa Medical Society.

COUNTY ACTION . . . Des Moines-Louisa County Medical Society has recorded itself in favor of orderly local hospital planning and opposed to costly duplication of equipment and facilities. The physicians are urging Burlington to maintain Memorial Hospital as the principal general and acute hospital.

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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DECEMBER 1973

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The Question Box



by EDWARD C. LAIRD, M.D.

Edward C. Laird, M.D., Storm Lake, is a young and energetic newcomer (1971 U. of I. medical graduate) to Iowa's physician ranks. Dr. Laird served in the IMS House of Delegates for the first time in October. He represented the Buena Vista County Medical Society.

How would you characterize your first participation in the Iowa Medical Society House of Delegates?

My first participation in the IMS House of Delegates was primarily an educational experience. I learned much about the mechanics and scope of the Iowa Medical Society. I had not realized the IMS is truly an effective action organization for the M.D.'s. Secondly, it was a pleasure to make new acquaintances and to renew old ones—especially with those who share common interests and goals.

Was your service as a reference committee member interesting and worth the time?

It was most interesting and well worth the time to serve as a member of the Reference Committee on Miscellaneous Business. In fact, I was honored to have this trust placed in me, as one of those "hippy, long-haired young docs."

As a young physician in practice only a short time, do you feel your contemporaries have much understanding of and positive feeling for the way the Iowa medical profession is organized and functions?

Until the recent session of the IMS House of Delegates I had a pretty negative attitude about the Medical Society. This feeling is probably shared by a majority of my contemporaries. I came away from this first session feeling that if the IMS does not represent the prevailing desires of Iowa physicians, then it is our own damn fault for not investing adequate time and energy to make it such.

Do you think of ways in which the interest of the younger physician might be sparked?

There is no substitute for "getting involved." And this is why I feel most of my contemporaries do not look upon the IMS as "their" organization. If we can involve these men of the younger generation then we shall find they, too, will look to the IMS as their organization.

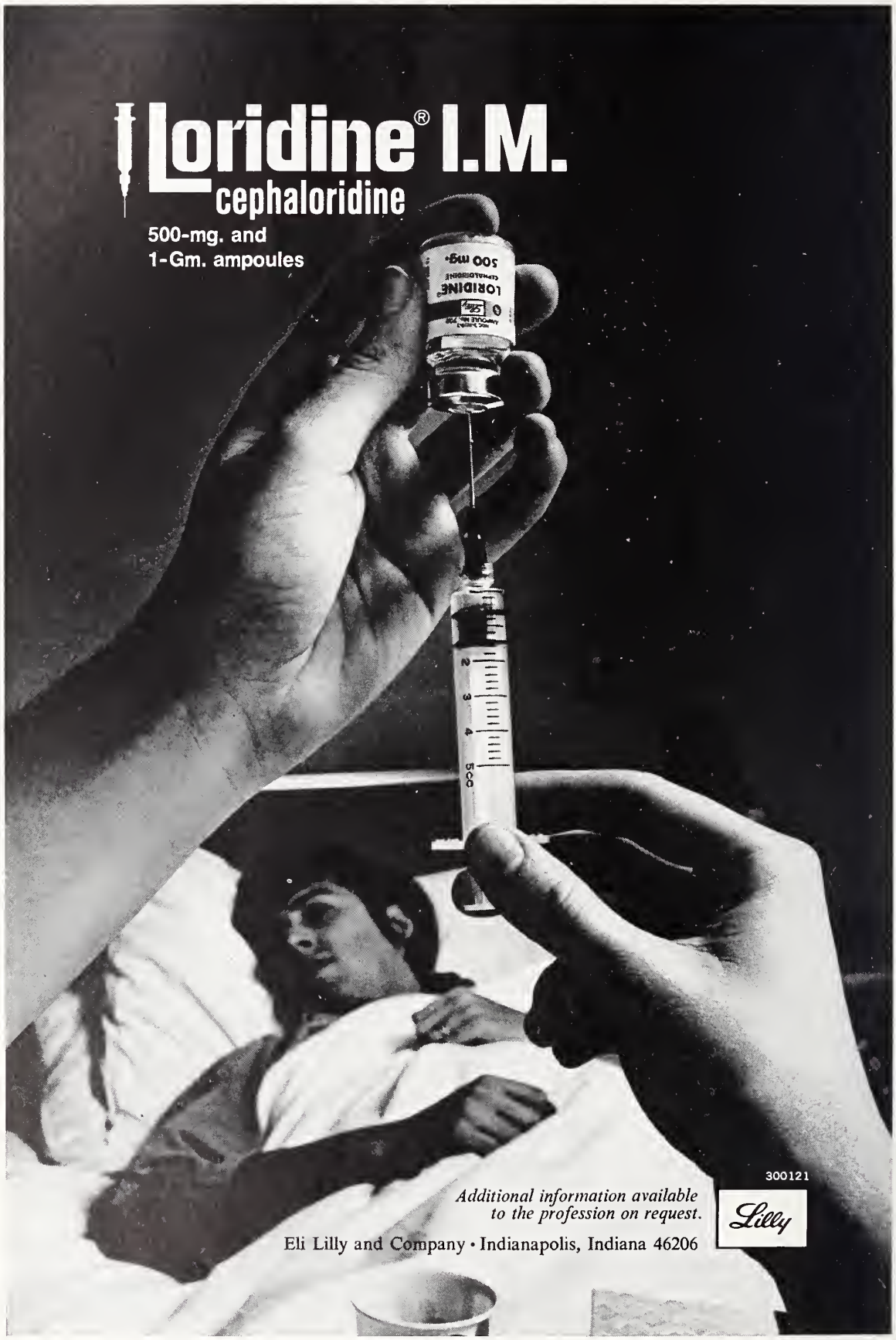
Are you finding your work as an Iowa family practitioner satisfying?

Definitely, yes! But frustrating as hell! As a fledgling of the endangered species of GP's who come back to their home towns to practice with their own family doctor—I find the work most gratifying but frustrating that it is not enough. It is the age-old conflict between sophomoric idealism and experienced reality.

Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Dec. 3-5	Pediatric Nutritian
Dec. 3-6	Cardiology Today
Dec. 5	Ophthalmology Clinical Conference
Dec. 6	What's New in Stroke?
Dec. 7	Cardiac and Respiratory Disease Conference
Dec. 8	Iowa Clinical Society of Medicine
1974	
Jan. 5	Ophthalmology Clinical Conference
Jan. 28-31	Cardiology Today


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Summary of IMS Involvement

A. J. HAVLIK, M.D.
Tama

I AM PLEASED to present this informational report to the 1973 Iowa Medical Society House of Delegates on behalf of the Board of Trustees. The Board intends this as an introduction to the important and specific business which is before us in this first "regular" session of the House. We desire in this report to provide you, the delegates, with an overview of the Society. We are extremely hopeful that our stock-taking presentation will serve as a useful backdrop for the deliberations of the next two days.

We know—as you do—that there is strong interest among Iowa physicians in this weekend session of the House of Delegates. This interest is clearly in order. We have two measures before us that bear heavily on the destiny of our 123-year-old Iowa Medical Society. In the next 48 hours, or less, you, the medical legislators of Iowa, will make significant decisions affecting yourselves and your colleagues. Please be assured you have (1) the commendation of the Board of Trustees for accepting this responsibility, (2) the Board's full cooperation in evaluating these matters, and (3) its good wishes as you pursue this work.

It is not our wish to consume a disproportionate amount of your time with this report. We have no desire to lull you with purposeless rhetoric. We share your wish to expedite the business of the House. However, we likewise feel a sense of responsibility, as principal officers of the Society, to submit certain facts and observations at this important juncture in our organizational life. These comments are offered in a sincere belief they will be of value as you contemplate what influence the Iowa Medical Society is to be in the months and years just ahead.

Dr. Havlik is a trustee of the Iowa Medical Society. These remarks were presented by Dr. Havlik to the IMS House of Delegates on Friday, October 12, 1973. Notation of their presentation is made at the appropriate point in the proceedings of the House which appear in this issue of the JOURNAL OF THE MEDICAL SOCIETY.

FIRST REGULAR SESSION

This first "regular" meeting of the House is authorized under Article and By-Law provisions adopted in 1972. It was ordered in April at the "annual" meeting of the House of Delegates. Please be mindful that our governing language now requires an "annual" meeting each year and makes optional a "regular" meeting. There are still provisions for "special" meetings of the House when circumstances require. Thus, in this instance, this weekend, we come together for the second time in 1973 in a "regular" session of the House.

In April the House of Delegates assigned two specific matters to two committees of the Society with instructions that they be attended to as necessary and made ready for consideration at this session. I refer (1) to the fiscal status of the Society, and (2) to the possible reapportionment of this House of Delegates. In the interval between April 30 and today the Board of Trustees has provided information and counsel on these topics as requested to (1) the Special Committee to Study Society Finances, and (2) the Standing Committee on Articles of Incorporation and By-Laws. These two committees have performed their duties and their reports are in your hands for evaluation.

As mentioned, this report of the Board of

Trustees is a kind of prologue or starting point. Any organization worth its salt must evaluate its fiscal and structural status from time to time. In doing so we believe it is important initially to review basic goals and objectives. The declared purposes of the Society are eloquent, and they are understandably ambitious. The 10 stated purposes may be paraphrased as follows:

- *To advance medical science and knowledge.*
- *To improve health and protect human life.*
- *To promote medicine and public health.*
- *To organize the state's profession and make it a part of a national federation.*
- *To foster medical education.*
- *To seek just medical laws.*
- *To secure the profession's material and mutual rights.*
- *To inform the public on vital medical issues.*
- *To assure high ethical conduct by the profession,* and finally
- *To find the wherewithal to do the foregoing.*

These all-encompassing aims stand inconspicuously in the background and quietly permeate the broad endeavors of our medical profession in Iowa. In addition to these, but not recorded in any official language, are two further purposes which many Iowa physicians regard as more specific and more significant. These supplementary goals are undeniably important, and they are clearly implied in the stated purposes. In forthright language many members believe the Iowa Medical Society should exist primarily:

- *To assure the Iowa physician his position as captain of the health care team,* and
- *To obtain for the Iowa physician an equitable reimbursement for his services and a free practice environment.*

Your officers accept these as fundamental objectives and contend that they—along with the formal 10—have been achieved in very large measure. Now, can we support this claim? Obviously, it would carry us well into the night if we detailed those many Society involvements which have served the specific interests of its member physicians. Let me simply refer to nine broad areas of involvement as a framework for our thinking this weekend:

1. **NATIONAL HEALTH INSURANCE—** For at least three decades the Society has been in the vanguard of states which has led a successful opposition to the nationalization of health care. The Forand Bill, the Murray/Wagner/Dingell Bill and the King-Anderson Bill are examples of federal legislation which have been aggressively opposed by the Iowa Medical Society. We must acknowledge the seemingly inevitable compromises, but we can report that to this day we do not have a totally federalized health care system. And we now have widely-supported alternatives in the legislative hopper to counter the proposals of those powerful advocates of full and costly nationalization.

2. **PRIVATE ENTERPRISE FINANCING—** The Society was responsible for the creation of Blue Cross and Blue Shield in the 1940's. This bold effort was undertaken to deter the enactment of compulsory governmental health care. Today the Blues constitute a major health care financing mechanism. As an indication of the magnitude of Blue Shield alone, it paid $52.3 million to physicians in 1972 and $45.8 million in 1971. This House of Delegates has been directly and deeply involved in approving, modifying and rejecting programs devised by Blue Shield. This time consuming and vital chore has not been all vanilla but the resulting economic benefit to Iowa physicians has been of tremendous consequence. The Usual, Customary and Reasonable (UCR) concept, which has gained significantly in its acceptance over the past several years, appears to hold considerable promise for the future. Of additional importance and fiscal benefit to Iowa physicians has been the Society's ongoing and good liaison with the total private health insurance industry.

3. **GOVERNMENTAL CARE PROGRAMS—** In the realm of care for the needy, the Society has been heavily involved, successively, in the vendor payment program, the Kerr-Mills or MAA program, and currently the Medicaid or Title XIX program. State enabling legislation was required for Title XIX, and through the Society's influence, such major provisions as usual and customary fees, use of a private carrier and free choice of physician were embodied in the law. Various attempts have been made to reduce fees under these several programs. The Society has intervened when this has been threatened and while services have

been reduced to accommodate budgets in some instances, fees have been held at established levels.

The vendor payment mechanism was advocated by this House of Delegates in the 1950's as a means of assuring that payment for services rendered the indigent actually reached the physician. Implementation of this recommendation was sought and achieved by the Society. And while it was a successful response to a mandate of the House of Delegates, it has come back to haunt us for now it is the precedent used to disallow the direct billing option under Medicaid.

The Veterans Hometown Care and the Military Dependents programs are other examples where the influence and clout of the Society accrued to the economic gain of member physicians.

A word about Medicare is in order. We strongly opposed this approach to providing care for the elderly. In its implementation Medicare has felt the impact of the Iowa Medical Society and medicine in general through the direct billing option and through the use of Blue Shield as the Part B carrier. You should be aware that Blue Shield disbursed $20.4 million to Iowa physicians in 1972 in Part B benefits.

4. **NATIONAL MEDICAL INVOLVEMENT**—For a small state Iowa has had a significant influence on medical affairs at the national level. For example, a principal role was played by the Iowa Medical Society a few years ago in securing national acceptance of the usual and customary fee philosophy and in firming up the definitions of these terms. Earlier, the Society helped gain authorization to establish the Council on Medical Service of the American Medical Association. This body has provided significant national medical leadership in third party financing. Through the years, the Society has had prominent representation on AMA committees and councils; Donovan Ward was Iowa's second AMA president and served in 1965; our delegates have served ably and frequently as chairmen and members of AMA reference committees.

5. **LEGISLATION & GOVERNMENTAL INVOLVEMENT**—Legislatively and in other governmental areas, the Society has been in the forefront at the state and national levels. Physician interests have been fought for and secured (1) in governmental appointments to such bodies as the Board of Medical Examiners, the Board of Health, etc., (2) in the passage of such beneficial legislation as Keogh and Professional Corporation and Good Samaritan, and (3) by contrast, in the defeat of chiropractic and other ill-advised legislative measures. In accordance with views presented at the April House of Delegates session and in conferences with the chairman of the Legislative Committee, the Board of Trustees is now exploring ways of strengthening the Society's legislative program while, at the same time holding expenses in line. We face changing legislative circumstances which are most challenging.

6. **RELATIONS WITH HOSPITALS**—Over a five-year period in the 1950's the Society devoted much of its energy to seeking and obtaining a statutory clarification of the relationship between the physician and the hospital. This effort included an extended and costly court case and culminated in 1957 with passage of House File 21. This outcome clearly established that a hospital cannot practice medicine in the State of Iowa and it precludes an employer-employee relationship between a physician and a hospital. The law remains intact even though certain exemptions have been made to it; for example, the recently passed HMO enabling legislation has an optional provision which allows either a contractual or salaried arrangement. We find ourselves closely associated with hospital officials in the pursuit of many activities and programs. Our common interest is obvious in such areas as PSRO, QAP, the emerging residency programs in community hospitals, HMO's, and so forth.

7. **MEDICAL EDUCATION**—The Society has had a consistently good relationship with the College of Medicine and this has been mutually beneficial. Growth of the College has been encouraged and stimulated; increasing support of deserving Iowa students has been provided through the Scanlon Medical Foundation, and post-graduate study opportunities have been and are being tailored to the needs and desires of IMS member physicians. Continuing medical education is the subject of a report before you this weekend; this whole subject has far-reaching implications for the medical profession.

8. **INTERPROFESSIONAL AND PUBLIC**

RELATIONS—The Iowa Medical Society has been a leader in the formation and operation of such bodies as the Iowa Health Council and the Health Planning Council of Iowa. We have pursued a deliberate program in our relations with osteopathic physicians and surgeons and this has progressed to the point where D.O.'s are now eligible for membership in the Society.

9. **PEER REVIEW**—The important matter of peer review has received much attention from the Society in recent years. Stepped-up peer review efforts have led to the formation of the Iowa Foundation for Medical Care, a physician-controlled instrument to assure that quality medical care is delivered in appropriate quantity with equitable reimbursement. The Foundation has received wide support in its efforts to become the Professional Standards Review Organization (PSRO) in Iowa.

These are broad areas of successful Society endeavor. We have acknowledged that success is more difficult to achieve in today's climate. It has been observed in this House, as recently as April, that a "new environment" exists wherein lawmakers and consumer-advocates have become much less willing to accept the points of view expressed by specific organizations. We have continued our efforts in the legislative arena but the successes are admittedly more difficult to achieve. Just how active our role will be in the ensuing months and years is contingent upon the decisions made this weekend.

As you well know, the executive powers of the Society are entrusted to and carried out by the Board of Trustees. The Board oversees the financial affairs of the Society, and is responsible for the acquisition, disposition and maintenance of property, subject to general instruction from the House of Delegates. The Board is responsible for the employment and general supervision of staff personnel. To accomplish these tasks the Board meets once a month or oftener.

This extensive involvement permits the Board to observe the evolving nature of the Society's total program and compare the performance with other state societies and professional organizations. The conclusion of the Board is readily apparent to you—we feel the Society's record is an enviable one—one which stands up exceedingly well alongside the purposes we enumerated earlier. The Medical Society is looked to for leadership by organizations and agencies across the state. These laudatory remarks do not mean to imply we have no room for improvement; on the contrary, there are many areas in which we can do a better job for the membership and the public.

EXCELLENT RECORD

Considering the available resources, the Board believes this Society has an excellent record of performance. In the 1970 periodic survey of physicians by the AMA Center for Health Services and Development, the 1969 average net income for physicians in the west north central states was $41,288. When this figure is multiplied by the 2,226 members listed as active in the 1972 IMS membership record a sum of just under $93 million emerges. Please note that the dues paid to the Society constitute three-thousandths of one per cent of this $93 million figure.

The Society has used its resources with ingenuity to mold a program which is equivalent to many larger states. We function as an important in-between or state-level catalyst, supporting our component county medical societies while holding a respected position in the American Medical Association.

In summary, it all boils down to this: Is the past performance of the Iowa Medical Society sufficiently creditable to mandate a continuation? And if so, how is this to be accomplished? These are two big questions before you this weekend. You can easily deduce from these remarks the Board of Trustees is anxious for the Society to maintain a strong and active organization, to work toward the basic goals we have noted.

In accordance with protocol, the Board of Trustees will serve as a reference committee to receive the report of the Special Committee to Study Society Finances. It will welcome testimony from those of you serving in this assembly. And it will present a report on Sunday which reflects this testimony. It will then be your task to determine our future course.

This report was submitted by Dr. Havlik on behalf of the Board of Trustees. The other members are J. F. Bishop, M.D., J. H. Kelley, M.D., R. H. Flocks, M.D., R. L. Wicks, M.D., R. M. Chapman, M.D., V. L. Schlaser, M.D., and T. A. Burcham, M.D.

Iowa Medical Society— A Worthy Mechanism

JAMES F. BISHOP, M.D.
Davenport

I WOULD LIKE to try to articulate in your behalf some of the things I think may be bothering you since they are things that bother me. We are proud of our profession and it offends us that we are so often placed on the defensive.

Today, the doctor tends to be frustrated, angry, and somewhat bewildered. I am sure you can just see the eyebrows of your lay friends shoot up to the hairline in astonishment at such a statement. "What does a doctor have to be frustrated about, making all that money? Why I hear lots of doctors have incomes in six figures!"—or words to that effect. I really don't know how many doctors have incomes in six figures but all surveys point to an average that is much more modest. However that may be, there seems to be nothing illegal or immoral about a six figure income. Any pro quarterback worth his salt is paid at least $100,000 for a six-month season plus all the fringe benefits. Basketball, baseball, hockey, and golf are equally lucrative for some of their stars. All these high priced athletes play their games very well, but we take care of sick people very well, too. When the doctor graduated from medical school he took a vow. It was a vow of service, not a vow of poverty. He works hard trying to satisfy a steadily increasing demand for an increasing variety of services and he is entitled to live well. He need not apologize for playing golf or owning a second car.

Dr. Bishop is chairman of the Board of Trustees of the Iowa Medical Society. These remarks were presented by Dr. Bishop to the IMS House of Delegates on Friday, October 12, 1973. Notation of their presentation is made at the appropriate point in the proceedings of the House which appear in this issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

The doctor is somehow to blame because he is in short supply. He has in some selfish manner, controlled the output of medical schools so he can maintain his monopoly. This despite the fact that your Scanlon Foundation has loaned almost half a million dollars to Iowa medical students. Also, despite the fact that a number of hospitals and medical societies around the state pay freshman medical students to spend time in these communities during the summer. No one pretends that these students make any contribution to patient care at this stage of their education. Again, despite the fact that the preceptorship program to provide out-of-school experience for upper classmen depends for its success upon the generosity in time and expense of practitioners all around the state. The developing family practice residency program will never get out of the incubator without the hard work and unpaid help of the hospitals' medical staffs. The doctor who is working 50 to 60 hours a week is not looking to suppress competition. He is looking for help.

PERSONAL FACTORS

Somehow it is the doctor's fault because he is so busy, but patients make him busy. There are ways in which those same patients could automatically increase available medical and other health care by 20-25%. If that seems a reckless statement, let's think about it. There are many people who eat too much, smoke too much, drink too much, and drive too fast and often combine the last two to their even greater peril. More than 56,000 people were killed on the streets and highways of this country last year. Those who died on the spot required the attention of at least a medical examiner. Others made it to emergency rooms where they expired despite the doctors, nurses, tech-

nicians, and others whose frantic efforts were in vain. Some of the injured lasted through varying periods in intensive care units and on trauma floors where the concentrated attention of many people still was not enough. In addition to these fatalities, there are some three million or more whose injuries required professional care of varying time and complexity. These are things people do to themselves—and to each other.

The hazards of too much eating, smoking, and drinking are well known and are under the direct control of each individual. These excesses are not compulsory. Whatever happens as a result is the individual's own fault but he still has to be taken care of. Common sense and moderation seem a simple way to increase the supply of health care. These, though, are things people must do for themselves and that seems too much to ask.

The doctor is badgered and frustrated by the increasing encroachment of the government with its blizzard of paper work, its restrictions, and its broken promises. Despite the warnings and objections of medicine, Medicare and Medicaid were launched. According to the advance notices, no one was to be an object of charity and each could choose his own doctor who would be paid his usual fee. As we all know, this has become a farce with fee reductions, retroactive refusal to pay hospital bills, and dire warnings of disciplinary measures if we fail to shape up to regulations, sometimes before they are written. Yet, some can't wait for total government health care.

GOVERNMENT RECORD

I think we can be forgiven if we review such sentiments with some cynicism because the government's track record just is not that good. The government put us in Viet Nam, then did not have the political courage to win or get out. The government has fueled a consuming inflation which it lacks the political courage to control. The government has created a national debt beyond all comprehension. The moment a newborn baby arrives, he already owes over $2,200. No wonder the first thing he does is take a deep breath and yell. The government subsidized a massive sale of grain which promptly disrupted our storage and transportation facilities. It produced a scarcity in our country with promise of rocketing prices of bread and meat. The government has been trying for 150 years or so to deliver the mail and how is your mail service? Any shining faith in the government's ability to solve all problems hardly seems justified.

We have our problems, too, with the news media, both printed and electronic. It seems that these two maiden ladies would rather be mad at us. There is no effective way to answer a slanted headline and news story with a letter to the editor which is usually buried among several others. A biased television story—usually labeled a documentary—leaves its imprint and is gone. There is no provision for setting the record straight. I will not belabor the matter further except to point out that the highly vaunted freedoms of the press and of the air are free only to those who have access to them.

HEALTH SYSTEM

We hear frequently that the health care system of this country has broken down. It is a well known principle of propaganda that a statement, however fallacious, repeated often enough becomes accepted as truth. The health care system of this nation has not broken down and it will not do so unless unduly tinkered with. The system is not perfect since seldom in the field of human endeavor does one find perfection. It is better than it was but not as good as it can be if its improvement is left in the hands of health professionals.

Among us there is suspicion and concern about this newfangled foundation for medical care, and there is an ominous ring about PSRO. Both seem to suggest further regimentation of medical practice and indeed this is true. Certainly, insurance carriers will not pay the Foundation to increase physicians' fees. The carriers can realize on their investment only if health care costs come down. Responsibility for PSRO has been delegated to physicians for at least two years during which they have a chance to demonstrate the ability to carry it out. The ultimate decision concerning such ability will reside in a branch of the government, hence the outcome is unpredictable. All this despite the fact that medicine has policed itself with far greater conscience and effectiveness than has any other profession. Long before any federal price freeze, state and county societies have been alert to detect and control poor professional performance and ex-

cessive charges. In passing, it is interesting to recall that, before the price freeze, whenever an increase in the cost of living was announced, increasing medical expenses always headed the list of causes. Since the freeze, medical and hospital charges have been rigidly controlled yet the cost of living continues to climb apace. The major fault must lie elsewhere.

This Society has broad representation on both the Iowa Foundation for Medical Care and on its review committees. This will assure the utmost vigilance in protecting your right to care for your patients as you think best. Further reassurance than that is not possible. The foundation concept is spreading rapidly, still under physician control, and PSRO is the law of the land. What stormy weather these two innovations will lead us into is beyond all prediction.

UNION CONSIDERATION

Goaded by their sense of frustration and anger, some among us feel that the solution to our problems lies in a union. This opinion is their privilege and their right to it cannot be denied. However, it seems to me that the goals and methods of unionism are utterly incompatible with the ethics and professionalism of medicine. The primary purpose of a labor union is to gain ever more material benefits for its members. The traditional responsibility of medicine has been to increase the quality and quantity of medical care. The accomplishments toward this goal are legion. Those who wish to embrace the union principle argue that only by this route can they impose their wishes upon government, insurance carriers, employers, and other portions of society. A labor union exerts its influence to a large extent through two measures: the ballot box in general elections and the strike. The strike consists of two elements: a refusal to work and a refusal to permit anyone else to work. Without a strike, or the threat of one, the pressure a union can exert is greatly diminished. Those who espouse medical unionism say there is no thought of a strike against patients. If not against patients then against whom could a strike be directed? Against the government? Against insurance carriers? Or employers? A strike against these third parties could involve little more than refusal to fill out forms. It would then be a matter of no tickee, no washee. No forms, no compensation for services rendered, a situation over which no third party could be expected to mourn. The only target of a strike would be our ultimate employer, the patient, and a strike against him seems inconceivable. However, the future is murky and one cannot say with certainty today what may happen next week. Firemen, policemen, nurses, teachers, letter carriers—proud professionals dedicated to service—have at various times felt so frustrated and trapped that they resorted to the desperate, destructive measure of a strike.

Physicians sometimes seem to regard their medical society as an adversary. This is certainly not the case. The medical society cannot always be all things to all people. Like any other democratic organization, this one sometimes has difficulty finding its way, moving too slowly for some and too rapidly for others. Sometimes the direction it moves is wrong, being too far this way or that way, depending upon varying points of view.

You, as members of this House, bring to your deliberations here the wishes and opinions of your constituents in all parts of the state. You will not always agree but bring your conflicts here and hammer out your answers on the anvil of argument. Controversy and compromise are the bread and wine of democracy. The decisions you reach will not always please everybody and may not entirely satisfy anybody but they will reflect the middle ground on which most people can live. It is in this House that Society policy is made and once your actions are taken, your officers and your staff, in duty and desire, will carry out your instructions. It is hoped that you and your constituents at home will do likewise. We can close our ranks, then, and resist the petty differences that might divide us.

BROAD SUPPORT

Strengthened by such broad support, those whom you have chosen to do so can sit down in councils with government and other third parties and tell them with confidence which of their proposals the doctors of Iowa will support and which they will reject. All proposals having to do with direct patient care must be examined most critically and approved only when we are satisfied there is no interference with good care as we know it. Anything less we must reject. Much that is uncertain lies ahead. We can meet it best if we meet it together.

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.



United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report,* the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

OFFICIAL PROCEEDINGS

1973 REGULAR SESSION
HOUSE OF DELEGATES
OCTOBER 12-14, 1973
DES MOINES, IOWA

(Alphabetical Index—Page 599)

FRIDAY SESSION, OCTOBER 12, 1973

The first regular meeting of the Iowa Medical Society House of Delegates was called to order at 4 p.m., Friday, October 12, by the Speaker, L. D. Caraway, M.D., of Amana. The action of the 1972 House of Delegates in providing for annual and regular meetings of the House, in addition to a separate scientific session, was reviewed by Dr. Caraway. He advised this is the first regular meeting, and the business is to be conducted in the same manner as the annual meeting. He invited comments from the delegates regarding ways to structure future meetings.

The House approved the taking of attendance by signed registration cards. There were 79 delegates, 15 voting alternates and 13 ex-officio members present.

COUNTY	DELEGATE
Allamakee	C. R. Rominger*
Appanoose	A. S. Owca
Black Hawk	G. R. Clark
	R. S. Gerard
	D. E. Conklin
	A. M. Dolan*
Boone	E. E. Linder
Bremer	V. H. Carstensen
Buena Vista	E. C. Laird
Calhoun	R. P. Ferguson
Cass	T. J. Payne
Cerro Gordo	W. V. Wulfekuhler
	R. M. Powell*
Cherokee	G. E. Michel
Clarke	J. D. Kimball
Clay	Mary L. Gannon
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Crawford	D. J. Soll
Dallas-Guthrie	E. E. Lister
	W. A. Seidler, Jr.
Davis	J. R. Scheibe*
Decatur-Ringgold	E. E. Gamet
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	L. F. Wallace
Dickinson	D. F. Rodawig, Jr.
Dubuque	R. T. Melgaard*
Emmet	R. J. Dawson
Franklin	R. E. Munns
Grundy	D. R. Kruschwitz
Hamilton	G. A. Paschal
Hancock-Winnebago	N. D. Thede
Hardin	T. C. Graham
Harrison	J. W. Barnes
Iowa	V. L. Moldenhauer*
Jasper	T. E. Kiernan
Johnson	R. C. Brown
	S. W. Greenwald
	K. J. Judiesch
	C. E. Radcliffe
	P. M. Seebohm
	R. D. Whinery
Kossuth	M. G. Bourne*
Lee	G. C. McGinnis
	J. E. McGee*
Linn	R. A. Sautter
	C. R. Aschoff
	R. W. Conkling
	R. M. Quetsch
	J. H. Lohnes
Mahaska	S. A. Smith
Marion	J. E. Griffin*
Marshall	W. T. Shultz
	R. R. Widner*
Monona	J. L. Garred
Montgomery	Oscar Alden
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Page	K. J. Gee
Pocahontas	James Gannon
Polk	John Hess, Jr.
	W. R. Hornaday, Jr.
	J. I. Hostetter
	C. H. Denser, Jr.
	R. K. Bunten
	D. C. Young
	A. N. Smith
	D. O. Newland
	N. K. Rinderknecht
	W. K. Downing*
	Lester Beachy*
	L. O. Ely*
Pottawattamie-Mills	M. E. Olsen
	Hormoz Rassekh
	A. L. Sciortino
	R. K. Fryzek
Poweshiek	H. R. Light
Scott	D. A. Bovenmyer
	A. W. Boone
	J. F. Collins
Sioux	E. B. Grossmann, Jr.
Tama	A. J. Havlik
Union-Taylor	R. H. Kuhl
	R. W. Boulden
Wapello	L. E. Coppoc
Wayne	K. A. Garber
Webster	D. S. Egbert
	O. N. Glesne*
Woodbury	R. C. Larimer
	D. M. Youngblade*
Worth	B. H. Osten
Wright	C. P. Hawkins

* Alternate

LIAISON DELEGATE

C. W. Seibert

EX-OFFICIO MEMBERS OF THE HOUSE

R. H. Flocks
R. L. Wicks
R. M. Chapman
V. L. Schlaser
T. A. Burcham
J. F. Bishop
J. H. Kelley
H. G. Marinos
J. M. Rhodes
L. D. Caraway
L. W. Swanson
H. J. Smith
K. E. Lister

V. L. Schlaser, M.D., Secretary of the Society, moved that the minutes of the April 30, 1973 session of the House of Delegates be approved as published in the July 1973 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The motion passed.

The Speaker introduced those individuals seated at the head table and acknowledged with gratitude those delegates appointed to reference committees.

J. F. Bishop, M.D., Chairman, Board of Trustees, was introduced for the presentation of personal remarks. (See Page 569.)

An informational report from the Board of Trustees was presented next by A. J. Havlik, M.D. (See Page 565.) In his introductory comments, Dr. Havlik advised of the death of J. F. Paulson, M.D., on September 20, 1973. Dr. Havlik paid tribute to Dr. Paulson for his distinguished service as a Society trustee. The appointment of J. H. Kelley, M.D., Des Moines, as a successor to Dr. Paulson was announced by Dr. Havlik on behalf of the Board. Dr. Kelley will serve in this capacity until the next election of officers by the House at the annual meeting in 1974.

In addition to the two reports noted above, the attention of the House was called to a listing of current IMS projects and activities. This listing was provided in the delegates' folders. These informational items were not assigned to reference committees.

Reports of Officers

INFORMATIONAL REPORT OF THE BOARD OF TRUSTEES

Presented by A. J. Havlik, M.D.

(Not Referred to Reference Committee)

(See Page 565)

REMARKS OF J. F. BISHOP, M.D.,
CHAIRMAN, BOARD OF TRUSTEES

(Not Referred to Reference Committee)

(See Page 569)

Reports of Special Committees

INTERIM STUDY COMMITTEE/IMS FINANCES

Presented by Don O. Newland, M.D., Chairman

(Referred to Reference Committee on Board of Trustees)

At the Annual Meeting of the Iowa Medical Society, the Reference Committee on Reports of Officers was directed to conduct "an impartial and in-depth study of the finances of the IMS, and to present specific recommendations with respect to solidifying the Society's financial future" to the House of Delegates at its Regular Meeting in the fall. As a part of this charge, the committee is also to submit recommendations regarding membership dues.

We have met with officers and executive staff members of the Society in order to obtain pertinent background information regarding various projects and all activities related to the operation and administration of the headquarters office. Now that the committee has completed its assignment, members of the House of Delegates will have opportunity to consider and discuss this report in open hearings during this regular meeting. The Board of Trustees, serving as a reference committee, will preside at the hearings and, then, based on this report and the reaction to it, will develop final recommendations for consideration and action by the House at the concluding session on Sunday.

BACKGROUND MATERIALS

The committee had access to and carefully reviewed IMS financial data, as well as fiscal information about other state medical societies—i.e., Wisconsin, Illinois, Missouri, Ohio, Indiana, California, and Florida.

IMS:

Detailed analysis of 1972 expenditures
Yearly Dues Record—1960 to 1973 (Exhibit A)
Executive and Secretarial Staff Salaries

Other State Medical Societies:

Listing of total members and total dues income of all state medical societies (Exhibit B)

Information provided on confidential basis by 7 state medical societies re salary ranges and fringe benefits for their senior executive and senior executive assistants

Miscellaneous:

Review of 1972-73 reports concerning Society activities, committee functions, etc. (July 1973 JOURNAL OF THE IMS)

Without going into the details of our study, the committee will focus attention on (a) several factors affecting the Society's financial status, (b) pose a key question that must be answered by the membership, and (c) present specific recommendations regarding IMS financing. Members of the House who might wish to have questions answered will have the opportunity to do so at the reference committee hearing, at which members of this committee will be present.

FISCAL FACTORS

The Society has net fixed assets with a depreciated value of $217,251.52 which includes land, building, of-

fice equipment, and furniture. However, it does not have reserve or depreciation funds actually on hand. An estimated value of the Society's fixed assets based on comparative or appreciation experiences approximates $400,000.

The basic cause for our present fiscal situation stems from our eagerness to pay off our building and land debts. This was accomplished in seven years, beginning in 1966. As a result of this stepped-up payment schedule, as well as increasing expenses and activities, the Board of Trustees authorized the use of dues income remitted in advance of the actual year of membership for current year operating expenses. As a result, approximately $100,000 is needed at the present time to restore previously committed funds—i.e., dues received but not incurred, to provide sufficient cash flow to cover IMS operating expenses, and to create a depreciation fund for its real estate.

EXHIBIT A

IMS Dues History 1960-1973

1960	$ 80.00
1961	80.00
1962	90.00
1963	90.00
1964	90.00
1965	125.00
1966	125.00
1967	125.00
1968	125.00
1969	150.00
1970	150.00
1971	150.00
1972	150.00
1973	150.00

EXHIBIT B

State Society Dues Income

State	Total Active Members	Level of Dues	Total Dues Income
California	23,914	$135.00	$3,228,390.00
New York	23,628	100.00	2,362,800.00
Illinois	9,315	135.00	1,257,525.00
Pennsylvania	9,972	100.00	997,200.00
Michigan	6,322	135.00	853,470.00
Texas	10,149	80.00	811,920.00
Ohio	9,213	65.00	598,845.00
Minnesota	4,464	125.00	558,000.00
Wisconsin	3,829	145.00	555,205.00
Massachusetts	6,457	85.00	548,845.00
North Carolina	3,634	145.00	526,930.00
Washington	3,939	127.00	500,253.00
Indiana	4,000	120.00	480,000.00
Florida	6,293	75.00	471,975.00
New Jersey	7,266	60.00	435,960.00
Maryland	3,622	100.00	362,200.00
Georgia	3,373	100.00	337,300.00
Colorado	2,547	130.00	331,110.00
Kentucky	2,416	130,00	314,080.00
Iowa	2,039	150.00	305,850.00
Alabama	2,300	125.00	287,500.00
Missouri	3,557	75.00	266,775.00
Louisiana	3,068	85.00	260,780.00
Tennessee	3,222	80.00	257,760.00
Dist. of Columbia	1,706	145.00	247,370.00
Hawaii	1,200	205.00	246,000.00
Oklahoma	1,993	120.00	239,160.00
Connecticut	3,370	70.00	235,900.00
Oregon	2,049	115.00	235,635.00
Arizona	1,761	120.00	211,320.00
Virginia	3,243	60.00	194,580.00
Arkansas	1,383	125.00	172,875.00
Kansas	1,680	100.00	168,000.00
West Virginia	1,483	100.00	148,300.00
Alaska	300	450.00	135,000.00
Mississippi	1,277	100.00	127,700.00
Nebraska	1,216	100.00	121,600.00
New Hampshire	790	95.00	75,050.00
South Carolina	1,541	75.00	115,575.00
Nevada	444	260.00	115,440.00
Utah	990	115.00	113,850.00
New Mexico	815	130.00	105,950.00
Maine	908	100.00	90,800.00
Idaho	586	150.00	87,900.00
Montana	593	200.00	118,600.00
Delaware	500	140.00	70,000.00
North Dakota	443	150.00	66,450.00
South Dakota	435	125.00	54,375.00
Vermont	530	80.00	42,400.00
Wyoming	277	125.00	34,625.00

The total expense for the operation of the IMS in 1972 was $346,422.25 which included $36,713.10 as the final payment on the IMS headquarters building. As previously reported to the House the 1972 excess of expenses over income was $33,556.29, which as you will note was approximately the amount of the building payment.

The total IMS budget for 1973 is $318,000. The major 1973 IMS budget expenses fall into five general categories: (1) salaries and fringe benefits ($134,800) for 22 staff members—42% of the total budget, (2) physician and employee travel ($54,000)—17% of the total budget, (3) taxes and building maintenance ($39,300) —13% of the total budget, (4) legal and legislative expenses ($25,000)—8% of the total budget, (5) JOURNAL costs ($16,000)—5% of the total budget. These five items comprise 85% of the total IMS budget for the year 1973.

The other approximately $48,000 or 15% of the budget consists of such items as: annual scientific session, county society services, dues and subscriptions, general administrative expense, House of Delegates, office stationery and supplies, postage, telephone and telegraph and Woman's Auxiliary.

The committee wishes to comment specifically on the following:

1. *Salaries (42%):* The committee was informed in detail about the duties and responsibilities of the executive staff members, and was also provided information about their individual salaries and fringe benefits. In comparing this information with data obtained from the seven other state medical societies mentioned previously, it was obvious to the committee that neither the IMS salary structure nor the fringe benefits are "out-of-line" or, in some cases, comparable to those of the other states. Indeed, the Society is getting a generous return on its investment from its staff. As noted, salaries and fringe benefits make up approximately 42% of the total expenditures. This is below the 50% guideline recommended by many experts as a baseline for association salary budgets.

Staff provides services contracted for by other agencies, for which the Society is paid—e.g., Blue Shield (Field Service), Scanlon Medical Foundation/IMS, Iowa Foundation for Medical Care. The Board of Trustees assured the committee there is no conflict of interest insofar as providing these services is concerned.

2. *Physician and Employee Travel (17%):* The committee has some concern about the number of officers necessary to represent the IMS, and conduct its business, at AMA annual and clinical meetings. However, it does recognize that the Society is a leader among other state medical groups, and maintains a position of considerable influence with the AMA, primarily as a result of its active participation in meetings at the national and regional level.

The committee is pleased to note that, effective in 1973, the Board of Trustees approved a new reim-

bursement formula for travel to AMA annual and clinical sessions in an effort to reduce overall expenses in this regard:

a. Each of the three delegates and the alternate delegate receives a flat travel allowance of $500. You will recall that last year the House also increased the number of alternate delegates from one to three, and this becomes effective in January 1974.

b. The President and Chairman of the Board of Trustees are reimbursed actual expenses.

c. Other officers on the Board of Trustees who are able to attend AMA meetings receive a travel allowance of $300.

3. *Taxes & Building (13%):* This expense item represents primarily property taxes on the IMS building and land. The amount is not to any great degree controllable by the Board of Trustees.

4. *Legal and Legislative Expenses (8%):* Specific steps are being taken to significantly reduce expenses incurred as a result of the Society's legislative and lobbying activities, and the Board of Trustees will provide information about our legislative program in its report to the House.

5. *Journal (5%):* The IMS has a scientific JOURNAL of high quality. As the basic communication organ for physicians within the state it should maintain the prestige and image expected of the IMS. Expenses are kept at a realistic level.

KEY QUESTION

By its past actions in recommending and approving IMS involvement in a myriad of projects, special services, and negotiations, the House of Delegates, which is representative of the entire membership, has demonstrated its desire for an aggressive medical society that assumes a leadership role in all matters affecting the medical profession and the practice of medicine.

In its general study of IMS finances, the committee found that in response to directives of the House, there have been considerable achievements in both the altruistic and practical concerns of the medical profession. They have been sung to us chapter and verse on many occasions. Our record "in the public interest" is well documented, as are the ways in which the IMS has served the profession.

We haven't always been decisive winners in our continuing battle to preserve the right of physicians to practice medicine in an unencumbered relationship with their patients, and we're still in the thick of the fight. But we've had our share of victories. To reiterate some of the important achievements alluded to in the report of the Board of Trustees. . . .

. . . The Society has been instrumental in establishing the usual, customary and reasonable fee concept as the basis for paying physicians for services provided to their patients under all third-party financing programs. This has become the standard for negotiating fees under private as well as governmental programs. Private insurance, Blue Shield, Medicare and Medicaid are positive examples of our success in this regard.

. . . Under Medicare and Medicaid we were also able to preserve the principle of freedom of choice, to assure the designation of private intermediaries, and permit direct billing to the patient under Medicare.

. . . In Iowa, the state medical society is recognized . . . it is . . . the individual doctor's principal intermediary with Blue Shield, the private insurance industry, and the state and federal governments.

. . . The Society is in the forefront of PSRO activity, both statewide and nationally. By virtue of the willingness of Iowa physicians to engage themselves in a voluntary program to assure and enhance quality of care, we have developed a formal peer review system which culminated in the creation of the Iowa Foundation for Medical Care. This was accomplished well in advance of PSRO legislation. As a result, we are far ahead of most other states, and there is every reason to believe that the Foundation will be designated a statewide PSRO in Iowa.

While the medical profession is constantly fending off threats to the free practice of medicine, other groups are also fighting for their lives. The chiropractors want to expand their scope of practice and are actively pursuing this through the halls of the legislature; the pharmacists are anxious to have a more clearly defined role as a member of the health care team, and are exploring ways in which to become more closely associated with the physician in "drug product selection"; the hospitals—administrators and board members—want increasing responsibility for assuring quality review; podiatrists are seeking authority to prescribe and dispense all drugs without limitation; with the development of physicians' assistants and nurse clinicians, the medical profession may be faced with the issue of granting "independent practitioner" status to these individuals: and last, but not least, there is the almighty consumer who wants an increasing voice in judging quality of care, in determining how to pay for it, and who is to provide it.

In light of these developments—which are just a few among many—the committee feels we need a stronger, not a weaker Society. And, as we all know, "you get what you pay for."

In considering the inter-relationship between IMS activities and dues income, the physicians of Iowa must decide whether or not they want the Society to maintain at least its present level of involvement and leadership in all matters relating to health care delivery, health care financing, health care legislation, public health, etc.

If the answer is "yes," then it is not likely that expenses can be markedly reduced. If the answer is "yes," then the House will want to give serious and positive consideration to the following recommendations of the committee.

RECOMMENDATIONS

After an exhaustive study, it is the opinion of this committee . . .

. . . that a reduction in the services or quality of services of the IMS at the present critical time is not justified;

. . . that we need depreciation and emergency funds;

. . . that it would be false economy to re-mortgage or sell the building;

. . . that we cannot continue on a deficit spending program;

. . . that our outstanding personnel cannot be asked to do the job we expect of them without competitive remuneration;

. . . that our JOURNAL, scientific meetings and business sessions should be first class;

. . . that if we care to maintain our prestigious place

in society, we must have first class support to maintain a first class organization;

. . . that the doctors of Iowa must first recognize the quality of services provided by the IMS and supply the funds out of pride of membership in the IMS to insure its future for the benefit of us all.

In accordance with the above statements, the committee recommends that the Board of Trustees study and respond to the following proposals:

1. That our present and future real estate needs be evaluated, including the pros and cons of (a) mortgaging the building to obtain funds; (b) borrowing against fixed assets; (c) selling the building on a lease-back arrangement.

2. That expenses be curtailed where possible and appropriate.

3. That after evaluating all factors that have and may affect the fiscal affairs of the IMS, an appropriate dues increase be made effective January 1, 1974.

With the aforementioned in mind, the committee is hopeful that the Society will continue its efforts to assure that the physician receives a reasonable share of the health care dollar and, simultaneously, identify and maintain the physician as the "captain" of the health care team.

Respectfully submitted,
D. O. NEWLAND, M.D., *Chairman*
J. H. CODDINGTON, M.D.
R. J. DAWSON, M.D.
H. M. PERRY, M.D.
R. A. SAUTTER, M.D.

COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

(Referred to the Reference Committee on Miscellaneous Business)

In accordance with a directive from the Executive Council of the Iowa Medical Society, the Committee on Community Emergency Medical Services has considered and developed recommendations on the following two items:

1. A program to categorize emergency medical services of the state, which is being undertaken by a task force of the Governor's Advisory Council on Emergency Medical Services.

2. A request from the Iowa Heart Association and State Department of Health for IMS support and assistance in developing legislation which would permit a Certified Mobile Intensive Care Medic to perform the certain lifesaving procedures for which he is specifically trained.

CATEGORIZATION OF EMERGENCY MEDICAL SERVICES

I represent the Iowa Medical Society on the Governor's Advisory Council on Emergency Medical Services, and serve on the Council's Task Force on Hospital Emergency Facilities. The Task Force has undertaken a program to define EMS categories and to classify EMS facilities in the state. As part of an extensive and in-depth survey of hospital emergency service capabilities, all hospitals in the state have received questionnaires, and on-site visits have also been made. Information obtained from the questionnaires and on-site visits will be reviewed by the Task Force and subsequently, appropriate categorization classifications will be assigned. *AMA Guidelines for the Categorization of Hospital Emergency Capabilities* were used as a resource by the Task Force.

The Task Force has not as yet taken action on the selection of specific titles for the various categories of EMS capabilities. The AMA Guidelines utilize capability designations (i.e.—I/Comprehensive Emergency Service; II/Major Emergency Service; III/General Emergency Service; IV/Basic Emergency Service) and the Task Force is considering designation either by capability or geographic titles (i.e.—regional, community, area). Attached to this report (Exhibit I) is a draft of the proposed EMS categories, with suggested classification titles and the qualifications for each category. The Task Force is scheduled to meet on October 26, at which time it will select specific titles for the various EMS categories, as well as review the data collected from the hospital survey and assign each hospital to an appropriate EMS category.

In response to a request from the Task Force for official IMS endorsement of the categorization of EMS in the state, the committee submits the following recommendations:

RECOMMENDATIONS

That the Iowa Medical Society endorse the concept of categorizing emergency medical service capabilities in the State of Iowa:

That the Iowa Medical Society strongly urge the Task Force on Hospital Emergency Facilities of the Governor's Advisory Council on EMS to utilize classification titles such as published in the *AMA Guidelines for the Categorization of Hospital Emergency Capabilities* (i.e.—Category I/Comprehensive Emergency Service; II/Major Emergency Service; III/General Emergency Service; IV/Basic Emergency Service), plus an additional category indicating that a hospital does not have EMS facilities available (i.e.—"Hospital: No Emergency Facilities").

EXHIBIT I

(Proposed and Tentative Listings)

EMERGENCY SERVICE CATEGORIES

By "tailoring" the AMA's classifications in "Categorization of Hospital Emergency Capabilities," the Iowa Medical Society, the American College of Surgeons, the Iowa Society of Osteopathic Physicians and Surgeons, the State Department of Health, the Iowa Nurses Association and the Iowa Hospital Association have defined the following categories to be utilized by the Emergency Medical Service Facility Task Force/Governor's Advisory Council on Emergency Medical Services.

AREA EMERGENCY SERVICE (TF)*
(CATEGORY I—COMPREHENSIVE EMERGENCY SERVICE—AMA)
(COMPREHENSIVE EMS—IHA)

1. SCOPE OF CAPABILITY—able to deliver complete and advanced medical care for all emergencies.

2. THE EMERGENCY SERVICE WILL:

A. Be under the medical direction of an actively participating physician.

B. Be staffed at all times by experienced physicians,

* Classification titles as recommended by: TF = Task Force on Hospital Emergency Facilities/Governor's Advisory Council on EMS, AMA = American Medical Association, IHA = Iowa Hospital Association.

in either case, the physician should be at minimum, a second year post-graduate.

C. Be staffed at all times by a minimum of one full time R.N. trained in Emergency Room Nursing Care.

D. Be equipped with at least the following: airway control and ventilation equipment, cardiac monitor and defibrillator, CVP equipment, I.V. fluids, sterile surgical sets, gastric lavage equipment, drugs and supplies.

E. Have adequate physical facilities.

3. THE HOSPITAL WILL HAVE:

A. In-house coverage 24-hours a day by all medical specialties (*1.* Obstetrics *2.* General Surgery *3.* Thoracic Surgery *4.* Neurosurgery *5.* Orthopedics *6.* Cardiovascular Surgery *7.* Urology *8.* Pediatrics *9.* Internal Medicine *10.* Anesthesiology *11.* Otolaryngology).

B. A blood bank as defined by the American Hospital Association.

C. 24-hour in-house laboratory coverage.

D. 24-hour in-house radiological services, including angiographic capability.

E. Operating rooms immediately available to emergency room patients.

F. ICU/CCU.

G. 2-way communications with local ambulance service.

H. Helicopter landing capability.

REGIONAL EMERGENCY SERVICE (A) (TF)** (CATEGORY II—MAJOR EMERGENCY SERVICE—AMA) (GENERAL EMS—TYPE A—IHA)

1. SCOPE OF CAPABILITY—staffed and equipped for the medical and surgical specialties necessary to render resuscitative and life-support care to critically injured and seriously ill patients of all ages. Other specialty capability available within a reasonable time.

2. THE EMERGENCY SERVICE WILL:

A. Have physician coverage from in-house physicians or specific physicians on call from outside, available in less than 15 minutes.*

B. Be staffed by a minimum of one full time R.N., L.P.N., or equivalent paramedical personnel (trained specifically in Emergency Medical Service).

C. Be equipped with at least the following: airway control equipment, EKG equipment, cardiac monitor and defibrillator, CVP equipment, and gastric lavage equipment.

3. THE HOSPITAL WILL HAVE:

A. A physician on call in-house 24-hours a day or available from outside the hospital in less than 15 minutes.*

B. 24-hour laboratory coverage—technicians on call from outside available within 30 minutes.

C. A blood bank as defined by the American Hospital Association.

D. 24-hour radiological coverage available within 30 minutes.

E. Operating room available promptly.

F. ICU or CCU capability.

G. 2-way communication with local ambulance service.

* Under Sections 2 and 3, paragraphs A, physicians . . . shall be interpreted to include (minimally) specialists in: *1.* Internal Medicine *2.* General Surgery (with Thoracic Surgery capability) *3. Neuro Surgery 4.* Orthopedics *5.* Pediatrics *6.* Obstetrics *7.* Anesthesiology.

** Classification titles as recommended by: TF = Task Force on Hospital Emergency Facilities/Governor's Advisory Council on EMS, AMA = American Medical Association, IHA = Iowa Hospital Association.

REGIONAL EMERGENCY SERVICE (B) (TF)** (CATEGORY III—GENERAL EMERGENCY SERVICE—AMA) (GENERAL EMS—TYPE B—IHA)

1. SCOPE OF CAPABILITY—staffed and equipped for the medical and surgical specialties necessary to render resuscitative and life-support care to critically injured and seriously ill patients of all ages. Other specialty capability available within a reasonable time.

2. THE EMERGENCY SERVICE WILL:

A. Have physician coverage from in-house physicians or specific physicians on call from outside, available in less than 15 minutes.*

B. Be staffed by a minimum of one full time R.N., L.P.N., or equivalent paramedical personnel (trained specifically in Emergency Medical Service).

C. Be equipped with at least the following: airway control equipment, EKG equipment, cardiac monitor and defibrillator, CVP equipment, and gastric lavage equipment.

3. THE HOSPITAL WILL HAVE:

A. A physician on call in-house 24-hours a day or available from outside the hospital in less than 15 minutes.*

B. 24-hour laboratory coverage—technicians on call from outside available within 30 minutes.

C. A blood bank as defined by the American Hospital Association.

D. 24-hour radiological coverage available within 30 minutes.

E. Operating room available promptly.

F. ICU or CCU capability.

G. 2-way communication with local ambulance service.

* Under Sections 2 and 3, paragraph A, physicians . . . shall be interpreted to include (minimally) specialists in: *1.* Internal Medicine *2.* General Surgery (with Thoracic Surgery capability) *3.* Orthopedics *4.* Pediatrics *5.* Obstetrics *6.* Anesthesiology.

** Classification titles as recommended by: TF = Task Force on Hospital Emergency Facilities/Governor's Advisory Council on EMS, AMA = American Medical Association, IHA = Iowa Hospital Association.

COMMUNITY EMERGENCY SERVICE (TF)* (CATEGORY IV—BASIC EMERGENCY SERVICE—AMA) (BASIC EMS—IHA)

1. SCOPE OF CAPABILITIES—able to render resuscitative and life support services, transfers made under prior agreement with other hospitals.

2. THE EMERGENCY SERVICE WILL:

A. Be staffed by a designated and qualified physician on call 24-hours a day from outside the hospital (available within 15 minutes).

B. Be staffed by a qualified R.N. or L.P.N. on call in-house 24-hours a day.

C. Be equipped with at least the following: airway control equipment, gastric lavage equipment, I.V. fluids, EKG equipment, and monitor-defibrillator available to emergency room.

3. THE HOSPITAL WILL HAVE:

A. A designated physician on call from outside the hospital.

* Classification titles as recommended by: TF = Task Force on Hospital Emergency Facilities/Governor's Advisory Council on EMS, AMA = American Medical Association, IHA = Iowa Hospital Association.

B. Blood obtainable from established bank or local donor (available to the patient within 2 hours).

C. Laboratory capability available within 30 minutes.

D. Radiological technician available within 30 minutes.

E. Staffed operating room available within 30 minutes.

F. 2-way communication with local ambulance service.

OTHER
(Does not meet Criteria of Community Emergency Service)
SUB-MINIMAL EMERGENCY SERVICE (TF)*
(OUT-PATIENT FIRST AID SERVICE—IHA)
(HOSPITAL: NO EMERGENCY FACILITIES—IMS)

MOBILE INTENSIVE CARE PARAMEDIC

The Iowa State Department of Health and the Iowa Heart Association have requested the support of and assistance from the Iowa Medical Society in developing legislation which would permit a certified Mobile Intensive Care Paramedic (MICP) to perform certain lifesaving procedures for which he is specifically trained and certified.

Ronald Eckoff, M.D., representing the Health Department, and David Gordon, M.D., representing the Heart Association, advised the committee that these agencies are developing a special advanced training program for ambulance attendants, which will supplement the 81-hour Emergency Medical Technician Ambulance training course presently available. They also called attention to H.F. 653, a bill requiring minimum standards for ambulance services, which was introduced into the first session of the 65th Iowa General Assembly, and will be considered during the second session, beginning in January 1974.

A MICP bill has been enacted by the State Legislature of West Virginia, and it is contemplated that any legislation developed in Iowa would be patterned after the West Virginia bill. A copy of the bill, along with a copy of the MICP job description, is attached to this report (Exhibits II and III). The committee has reacted favorably to the bill, and has expressed specific approval of the following provision regarding services that may be performed by a MICP:

"Notwithstanding any other provision of law, mobile intensive care paramedics may do any of the following:

"1. Render rescue, first aid, and resuscitation services;

"2. Perform cardiopulmonary resuscitation and defibrillation in a pulseless patient; and

"3. Where voice contact is maintained with a physician or surgeon, may, upon order of such physician, administer parenteral or intravenous solutions and injections of any of the following drugs:

a. Lidocaine

b. Atropine

c. Pentazocine

d. Any other drug or solution approved by the applicable bureau or division of the State Department of Health.

"Each paramedic must be individually certified to administer each specific drug or solution."

The Secretary to the State Board of Medical Examiners and representatives of the Legislative Service Bureau are assisting in the drafting of an appropriate bill to be introduced into the Iowa Legislature during its second session.

In reference to the development of a legislative proposal, it was pointed out to the committee that in the State of Oregon, the Attorney General issued a pronouncement which permits MICP's to perform certain lifesaving procedures under specific conditions, which made it unnecessary to seek legislative approval; hence, even though it would be desirable to develop an appropriate legislative proposal, other avenues to accomplish the same purpose should be explored.

The committee wishes to emphasize that under any MICP program, only qualified personnel would be approved or certified—e.g., those who have completed a comprehensive course, passed a thorough examination, and demonstrated their ability to perform knowledgeably and skillfully.

In response to the request from the State Department of Health and Iowa Heart Association, the committee submits the following recommendations:

RECOMMENDATIONS

That the Iowa Medical Society support the general concept of authorizing especially trained and certified mobile intensive care personnel to perform certain lifesaving procedures under specified conditions;

That the IMS Committee on Legislation consider the merits of supporting enabling legislation, including appropriate liability provisions, as well as a provision for the State Department of Health to establish standards and rules, with advice and counsel from an Advisory Council that would include representation from the IMS;

That, if IMS support of such legislation is deemed desirable, the Legislative Committee should consult with the Iowa Heart Association and Iowa State Department of Health in the development of an appropriate bill.

EXHIBIT II

JOB DESCRIPTION OF A MOBILE INTENSIVE CARE PARAMEDIC (MICP)
West Virginia Program

Capable of fulfilling the duties as outlined for the Emergency Medical Technician (EMT), plus:

A. Administer some medications for which he has been certified by the State Medical Licensing Board when contact is maintained with a physician.

B. Set up and administer IVs including venipuncture.

C. Maintain a working knowledge of EKG equipment and be capable of interpreting rhythm disturbances and treat patients with medications when voice contact is maintained with a physician.

D. Defibrillate pulseless patients.

The scope of these procedures provides the additional capacity for the Mobile Intensive Care Paramedic to function in specialized roles within the hospital when needed such as:

Coronary Technician

Inhalation Technician

Assist with obstetrical procedures

* Classification titles as recommended by: TF = Task Force on Hospital Emergency Facilities/Governor's Advisory Council on EMS, IHA = Iowa Hospital Association, IMS = Iowa Medical Society/Committee on Emergency Medical Services.

But *not* able to perform procedures where knowledge of the principles of emergency medicine is essential in the treatment of medical problems requiring sophisticated emergency care.

Background Requirements

Before acceptance in an MICP course, the applicant must be a graduate from a standard four-year high school (GED diploma accepted).

Certified by the West Virginia Department of Health, Emergency Health Services Unit, as an Emergency Medical Technician. Must be recommended as a candidate for MICP by a physician who has direct knowledge of the candidate's ability, and then satisfactorily complete the MICP course and be certified by the State Health Department.

NOTE: MICP must pass screening tests as administered by qualified personnel if and when deemed necessary in any or all of the following areas: (1) physical, (2) intelligence (I.Q. tests), (3) personality inventories, (4) emotional stability tests, (5) aptitude, (6) social, and (7) driver examination (defensive and emergency).

Application for Certification as Mobile Intensive Care Paramedic

A. The term "Board" as hereafter used refers to the Medical Licensing Board of West Virginia.

B. The term "Secretary" as hereafter used refers to the Secretary of the Medical Licensing Board of West Virginia.

C. Application for certification of Mobile Intensive Care Paramedic must be made by a physician licensed to practice in West Virginia *stating that the educational requirements have been fulfilled.*

D. Training requirements are outlined in the previous section for the Mobile Intensive Care Paramedic. As stated in Senate Bill #281, the course must be certified by Emergency Health Services Unit of the State Department of Health.

E. The minimum age of all applicants must be 18 years.

F. *All applicants must, prior to applying for certification to the Board, pass both written and practical examination that is administered by the Emergency Health Services Unit of the State Health Department.*

G. Partnerships, corporations, or associations consisting of physicians, and organized in accordance with West Virginia law, in addition to physicians in solo practice, may employ Mobile Intensive Care Paramedics.

H. The Secretary of the Board may issue temporary certification when credentials permit until the next regular meeting of the Board.

I. The Board shall after proper certification issue a one (1) year temporary permit to the Mobile Intensive Care Paramedic. After one (1) year, the Mobile Intensive Care Paramedic shall request a permanent certification which must be renewed by the applicant every two (2) years. Prior to permanent certification, the Board will cause the Emergency Health Services Unit of the West Virginia Department of Health to ascertain the competencies of the applicant prior to issuing a new certificate.

Requirements for Certification

A. Before being certified by the Board to perform as a Mobile Intensive Care Paramedic, an applicant shall be of good moral character and have satisfied the requirements of Emergency Health Services Unit of the State Health Department.

B. Whenever the Board determines that an applicant has failed to satisfy the Board that he should be certified, the Board shall immediately notify such applicant of its decision and indicate in what respect the applicant has so failed to satisfy the Board. Such applicant shall be given a formal hearing before the Board upon request of such applicant filed with or mailed by registered mail to the Secretary of the Board at Charleston, West Virginia, within ten days after receipt of the Board's decision, stating the reasons for such request. The Board shall within 20 days of receipt of such request notify such applicant of the time and place of a public hearing, which shall be held within a reasonable time. The burden of satisfying the Board of his qualifications for certification shall be upon the applicant. Following such hearing, the Board shall determine on the basis of these regulations whether the applicant is qualified to be certified, and this decision of the Board shall be final as to that application.

C. In hearings held in pursuant to this rule the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions.

Moral Character

A. Every applicant shall be of good moral character, and the applicant shall have the burden of proving that he is possessed of good moral character by submitting two documents to this effect.

B. All information furnished to the Board by an applicant shall be deemed material and such information shall be and become a permanent record of the Board.

C. All investigations by the Board in reference to the moral character of an applicant may be informal, but shall be thorough, with the object of ascertaining the truth. Neither the hearsay rule, nor any other technical rule of evidence need be observed.

Termination of Certificate

A. The certification of a Mobile Intensive Care Paramedic shall be terminated by the Board, when, after due notice and a hearing in accordance with the provisions of this Section, it shall find:

(1) That the Mobile Intensive Care Paramedic has held himself out or permitted another to represent him as a licensed physician;

(2) That the Mobile Intensive Care Paramedic has in fact performed otherwise than at the direction and under the supervision of a physician licensed by the Board.

(3) That the Mobile Intensive Care Paramedic has been delegated and performed a task or tasks beyond his competence;

(4) That the Mobile Intensive Care Paramedic is an habitual user of intoxicants or drugs to such an extent that he is unable to safely perform as a Mobile Intensive Care Paramedic;

(5) That the Mobile Intensive Care Paramedic has been convicted in any court, state or federal, of any felony or other criminal offense involving moral turpitude;

(6) That the Mobile Intensive Care Paramedic has been adjudicated a mental incompetent or whose mental condition renders him unable safely to perform as an assistant to a physician; or

(7) That the Mobile Intensive Care Paramedic has

failed to comply with any of the provisions relating to the Section pertaining to the methods of performance.

B. Before the Board shall terminate the certification granted by it to a Mobile Intensive Care Paramedic, it will give to the Mobile Intensive Care Paramedic a written notice indicating the general nature of the charges, accusation or complaint preferred against him and stating that the Mobile Intensive Care Paramedic will be given an opportunity to be heard concerning such charges or complaints at a time and place stated in such notice, or to be thereafter fixed by the Board, and shall hold a public hearing within a reasonable time. The burden of satisfying the Board that the charges or complaints are unfounded shall be upon the Mobile Intensive Care Paramedic. Following such hearing, the Board shall determine on the basis of these regulations whether the certification of the Mobile Intensive Care Paramedic shall be terminated.

C. In hearings held by the Board, they shall admit and hear evidence in the same manner and form as prescribed by law for civil actions.

Method of Performance

A. A Mobile Intensive Care Paramedic must clearly identify himself as Mobile Intensive Care Paramedic or by some other appropriate designation in order to insure that he is not mistaken for a licensed physician or physician's assistant. The Mobile Intensive Care Paramedic must wear an appropriate name tag—Mr., Miss, or Mrs. and surname plus PARAMEDIC.

B. A wallet size card furnished by the Board must be carried by the certified Mobile Intensive Care Paramedic bearing the name, address, date of issuance, number, expiration date, signature of certificate holder and Secretary of the Board. A recent photograph shall be affixed to the back of the card.

C. The Mobile Intensive Care Paramedic must be prepared to demonstrate upon request, to a member of the Board or other persons designated by the Board, his ability to perform those tasks assigned to him.

EXHIBIT III

MOBILE INTENSIVE CARE PARAMEDICS
(SENATE BILL #281)
West Virginia Proposal

An act to amend and reenact sections one and two, article three, chapter thirty of the Code of West Virginia, 1931, as amended; and to further amend said chapter by adding thereto a new article, designated article three-b, all relating to the practice of medicine and surgery in the state of West Virginia, and mobile intensive care paramedics:

Be it enacted by the Legislature of West Virginia:

That sections one and two, article three, chapter thirty of the Code of West Virginia, 1931, as amended, be amended and reenacted; and that said chapter be further amended by adding thereto a new article, designated article three-b, all to read as follows:

ARTICLE 3. PHYSICIANS AND SURGEONS

30-3-1. Evidence of qualification of practice; license required.

Any person practicing or offering to practice medicine and surgery in this state, with the exception of an assistant to a licensed physician, licensed podiatrist or mobile intensive care paramedic, shall be required to submit evidence that he is qualified to practice and shall be licensed as hereinafter provided.

30-3-2. Who deemed practitioner; limitations of article.

The term "practice medicine and surgery," as used in this article, shall be construed to mean the treatment of any human ailment or infirmity by any method. To open an office for such purpose or to announce to the public in any way a readiness to treat the sick or afflicted shall be deemed to engage in the practice of medicine and surgery within the meaning of this article: Provided, that the provisions of this article, with the exceptions of sections eight and ten, shall not apply to dentists, dental hygienists, nurses, optometrists, osteopathic physicians and surgeons, midwives, or chiropractors, regularly licensed or registered as such under the provisions of this chapter applicable to such professions and occupations, in the practice of their respective professions and occupations; nor to assistants to physicians, podiatrists, or mobile intensive care paramedics; nor to physicians or surgeons living in other states and duly qualified to practice medicine therein who shall be called in consultation into this state by a physician or surgeon legally entitled to practice medicine and surgery in this state; nor to commissioned officers of the United States army, navy or marine hospital service when in the actual discharge of their duties as such; nor to the practice of the religious tenets of any church in the administration to the sick or suffering by mental or spiritual means, whether gratuitously or for compensation: Provided, however, that sanitary and public health laws shall be complied with: Provided further, that no practices shall be used which may be dangerous or detrimental to life or health and that no person shall be denied the benefits of accepted medical and surgical practices.

ARTICLE 3-B. MOBILE INTENSIVE CARE PARAMEDICS

30-3B-1. Programs for ambulance and rescue squad personnel.

Any company, partnership, individual or governmental body operating an ambulance service or rescue squad may conduct a program utilizing mobile intensive care paramedics for the delivery of emergency care to the sick and injured at the scene of an emergency and during transport to a hospital while in the hospital emergency quarters, and until care responsibility is assumed by the hospital staff.

30-3B-2. Definition of mobile intensive care paramedics.

As used in this article, "mobile intensive care paramedics" means personnel who have been specially trained in emergency care in a training program certified and supervised by the unit of emergency health services of the West Virginia state department of health, and who are certified by the West Virginia medical licensing board as qualified to render the services enumerated in this article.

30-3B-3. Services that may be performed.

Notwithstanding any other provision of law, mobile intensive care paramedics may do any of the following:

(1) Render rescue, first aid and resuscitation services;

(2) Perform cardiopulmonary resuscitation and defibrillation in a pulseless patient; and

(3) Where voice contact is maintained with a physi-

cian or surgeon, may, upon order of such physician, administer parenteral or intravenous solutions and injections of any of the following drugs:

(a) Lidocaine,

(b) Atropine,

(c) Pentazocine,

(d) Any other drug or solution approved by the applicable bureau or divisions of the state department of health.

Each paramedic must be individually certified to administer each specific drug or solution.

30-3B-4. Immunity from civil liability.

No physician or surgeon, who in good faith gives emergency instructions to such paramedic, nor any such paramedic who renders such emergency treatment as provided for herein, shall be liable for any civil damages resulting from such emergency treatment.

The Committee on Community Emergency Medical Services is hopeful the House of Delegates will see fit to respond favorably to the recommendations contained in this report.

Respectfully submitted,

A. H. DOWNING, M.D., *Chairman*
R. E. CLARK, M.D.
R. D. ECKOFF, M.D.
J. F. KELLY, M.D.
R. C. LARIMER, M.D.
R. L. MORGAN, M.D.
D. J. OTTILIE, M.D.

Reports of Standing Committees

Committee on Articles of Incorporation and By-Laws

Summarized by K. L. Judiesch, M.D., Chairman

(Referred to the Reference Committee on Articles of Incorporation and By-Laws)

(Brackets indicate deletions, italics are additions.)

I. *Life Membership*

The April 1973 House of Delegates adopted the following resolution on eligibility for Life Membership and referred it to the Standing Committee on Articles of Incorporation and By-Laws.

"*Resolved,* That the Standing Committee on Articles of Incorporation and By-Laws be requested to develop appropriate language modifying the Articles of Incorporation and By-Laws to provide for Life Membership after a physician has practiced medicine for 50 years and has been a member of this Society for the last 15 consecutive years, and to submit said language at the next meeting of the House of Delegates."

The Committee in consultation with legal counsel believes the change can best be effected by revising the first sentence of Section 3 of Article III and recommends adoption of the following resolution:

Resolved, That Article III, Section 3 be amended to read as follows:

Section 3. Any physician who has practiced medicine for fifty years and has been a member of this Society for [thirty] *the last fifteen consecutive* years may be elected to life membership by the House of Delegates, providing his county medical society votes to present his name for such life membership in the Society and providing further that his regular and special dues for the current year have either been accepted at the headquarters of the Society or have been waived by the Judicial Council because of financial hardship.

II. *Eligibility for Office*

The April 1973, House of Delegates adopted a resolution as follows:

"*Resolved,* That the Standing Committee on Articles of Incorporation and By-Laws be instructed to draft appropriate language modifying the Articles of Incorporation and By-Laws to require a period of two years' membership before a physician shall be entitled to hold an office in the Iowa Medical Society, and to submit said language at the next meeting of the House of Delegates."

This requires an amendment to the last sentence of Article IV, Section 2 and Chapter I, Section 2 and to Chapter XIII. The Standing Committee on Articles of Incorporation and By-Laws recommends adoption of the following resolutions:

Resolved, That Article IV, Section 2 and Chapter I, Section 2 be amended so that each such last sentence would read as follows:

ARTICLE IV

Section 2. * * * These specified officers shall be elected by the House of Delegates on the last day of the annual meeting and eligibility to any office shall include citizenship in the United States of America and membership in good standing in this Society for the [five] *two* years immediately preceding election.

CHAPTER I

Section 2. * * * Any active or life member shall be eligible to any office within the gift of the Society, providing such member is a citizen of the United States and has been a member of this Society in good standing for [five years] *the two years immediately preceding election.*

Resolved, That Chapter XIII of the By-Laws be amended to read as follows:

CHAPTER XIII
LIAISON DELEGATES

No later than 15 days prior to the annual meeting of the Nominating Committee, the Liaison Committee shall submit to the Nominating Committee the names of four or more *active, direct* or life members of this Society in good standing for the preceding [five] *two* years, for the positions of Liaison Delegates. The names so submitted by the Nominating Committee will appear on the lists of candidates for offices and on the printed ballot referred to in Sections 4 and 5 of Chapter IV. From the names so submitted the House of Delegates shall elect two Liaison Delegates to serve as members of the House of Delegates and of the Executive Council as provided in the Articles of Incorporation. Liaison Delegates shall assume office upon adjournment of the annual meeting at which they were elected and shall serve for a term of one year and/or until their successors shall have been elected. A vacancy in the position of Liaison Delegates shall be filled by the Executive Council from nominations submitted by the Liaison Committee, of one or more active or life members of this Society in good standing for the preceding [five] *two* years, to complete the term of the elected Liaison Delegate.

III. *Reapportionment*

The April 1973, House of Delegates adopted a reso-

lution on reapportionment and referred it to the Standing Committee on Articles of Incorporation and By-Laws to prepare necessary implementing language for presentation at this meeting. In accordance with that action the Standing Committee after consultation with legal counsel submits the following resolution:

Resolved, That Chapter III, Section 3 and Chapter IX, Section 10 of the By-Laws be amended as follows:

CHAPTER III

Section 3. [Each component society which has made its annual report and paid its dues shall be entitled to send one delegate from each county within the component society to represent it in the House of Delegates of this Society. Each component society which represents an individual county only and which has more than twenty-five active or life members in good standing as of the close of the preceding calendar year shall be entitled to send one additional delegate for each such additional twenty-five active or life members in good standing (or major fraction thereof). Each component society which represents two or more adjoining counties and which has more than twenty-five active or life members in good standing from any county as of the close of the preceding calendar year shall be entitled to send one additional delegate for each such additional twenty-five active or life members in good standing (or major fraction thereof) residing in such county.] *Each councilor district shall be entitled to send one delegate for each fifteen (or major fraction thereof) active or life members of this Society who are members of a component society in the councilor district and who are active or life members of this Society in good standing as of the close of the preceding calendar year.* In addition, the [The] component society for student members shall be entitled to send one delegate for each [twenty-five] *fifteen* student members (or major fraction thereof) in good standing as of the close of the preceding calendar year, with the maximum number of delegates set at eight. *Such delegates shall be elected as provided in Chapter IX hereof.* In case any delegate of any component society *or councilor district, as the case may be,* is unable to attend any session, his alternate or any other alternate of said component *or councilor district, as the case may be,* designated by the chairman of the delegation, may be seated in his place for the period of said delegate's absence.

CHAPTER IX

Section 10. Sometime in advance of the annual meeting of the Society [each component society which has made its annual report and paid its dues shall be entitled to elect one delegate and one alternate delegate from each county within the component society to represent it in the House of Delegates of this Society. Each component society which represents an individual county only and which has more than twenty-five active or life members in good standing as of the close of the preceding calendar year shall be entitled to elect one additional delegate and one alternate delegate for each such additional twenty-five active or life members in good standing (or major fraction thereof). Each component society which represents two or more adjoining counties and which has more than twenty-five active or life members in good standing from any county as of the close of the preceding calendar year shall be entitled to elect one additional delegate and one alternate delegate for each such additional twenty-five active or life members in good standing (or major fraction thereof) residing in such county.] *delegates and alternate delegates to the House of Delegates of this Society shall be elected from each councilor district as follows: (1) each component society in the councilor district which has made its annual report and paid its dues and which has at least fifteen members shall be entitled to elect from its membership one delegate and one alternate delegate for each fifteen (or major fraction thereof) of its members who were active or life members of this Society in good standing as of the close of the preceding calendar year. No such component society shall be entitled to elect from its membership more than its proportionate share of the total number of delegates and alternate delegates in the councilor district. (2) Each component society in the councilor district which has made its annual report and paid its dues but which has less than fifteen members shall be entitled to combine with one or more similarly situated component societies in the councilor district for the purpose of electing delegates and alternate delegates and the combination of such component societies shall be entitled to elect from the combined membership one delegate and one alternate delegate for each fifteen (or major fraction thereof) of its members who were active or life members of this Society in good standing as of the close of the preceding calendar year. No such combined society shall be entitled to elect from its membership more than its proportionate share of the total number of delegates and alternate delegates in the councilor district. (3) Each councilor district is entitled to be represented by one delegate for each fifteen (or major fraction thereof) members in the district who were active or life members of this Society in good standing as of the close of the preceding calendar year and, if the number of delegates elected by March of any year does not equal the total number of delegates to which the councilor district is entitled, then the councilor district is entitled to elect a sufficient number of delegates and alternate delegates at large to provide full representation. In addition to the foregoing the* [The] component society for Student Members shall be entitled to elect one delegate and one alternate delegate for each [twenty-five] *fifteen* student members (or major fraction thereof) in good standing as of the close of the preceding calendar year, with the maximum number of delegates set at eight.

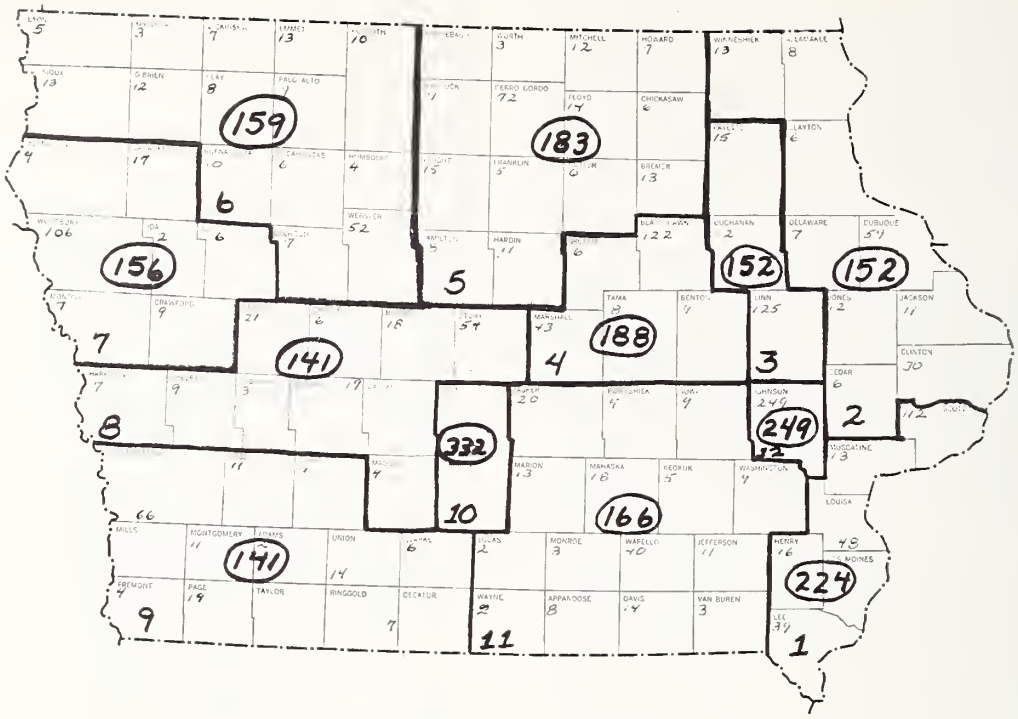
IV. *Councilor Districts*

The April 1973, House of Delegates suggested that the present Councilor Districts could be realigned without an amendment to the Articles and By-Laws and could be achieved by a simple action of the House of Delegates. The suggested realignment of districts is illustrated on the attached map. In order to place this before the House of Delegates for consideration, the Standing Committee is forwarding the following resolution to the House of Delegates for consideration but without specific recommendation:

Resolved, That the House of Delegates designate the Twelve (12) Councilor Districts of the Iowa Medical Society as follows:

Councilor District I. Counties: Lee, Des Moines, Louisa, Henry, Muscatine, Scott

Councilor District II. Counties: Cedar, Clinton, Jones, Jackson, Delaware, Dubuque, Clayton, Allamakee, Winneshiek



PROPOSED Realignment of Councilor Districts

Councilor District III. Counties: Linn, Buchanan, Fayette

Councilor District IV. Counties: Black Hawk, Grundy, Marshall, Tama, Benton

Councilor District V. Counties: Winnebago, Worth, Mitchell, Howard, Hancock, Cerro Gordo, Floyd, Chickasaw, Wright, Franklin, Butler, Bremer, Hamilton, Hardin

Councilor District VI. Counties: Lyon, Osceola, Dickinson, Emmet, Kossuth, Sioux, O'Brien, Clay, Palo Alto, Buena Vista, Pocahontas, Humboldt, Calhoun, Webster

Councilor District VII. Counties: Cherokee, Woodbury, Ida, Sac, Monona, Crawford, Plymouth

Council District VIII. Counties: Carroll, Greene, Boone, Story, Harrison, Shelby, Audubon, Guthrie, Dallas, Madison

Councilor District IX. Counties: Pottawattamie, Cass, Adair, Mills, Montgomery, Adams, Union, Clarke, Fremont, Page, Taylor, Ringgold, Decatur

Councilor District X. Counties: Polk, Warren

Councilor District XI. Counties: Jasper, Poweshiek, Iowa, Marion, Mahaska, Keokuk, Washington, Lucas, Monroe, Wapello, Jefferson, Wayne, Appanoose, Davis, Van Buren

Councilor District XII. County: Johnson

The Standing Committee considered two additional items which were not referred by the House of Delegates, but have been suggested as items to be brought to the attention of the House of Delegates for consideration.

V. *Reinstatement of Membership*

The present By-Laws, Chapter VI, Section 3, read in part as follows and require payment of dues for a delinquent year as well as the current year when a doctor wishes to rejoin the Society:

"Suspended members cannot be reinstated until the indebtedness for which they were dropped from the membership role of the Society has been discharged. Such indebtedness shall apply only to one year of delinquency."

The AMA recently amended its By-Laws to eliminate a similar requirement.

During the year 1973 by mutual consent of the Board of Trustees and the Executive Council, this provision of the By-Laws was waived. The Standing Committee feels that now is an appropriate time to recommend elimination of this requirement believing that it serves little useful purpose and is not a deterrent to a physician dropping his membership but may discourage a physician from renewing his membership. The Standing Committee recommends adoption of the following resolution:

Resolved, That the second and third sentences of Section 3 Chapter VI, of the By-Laws be, and they hereby are, stricken.

VI. *Direct Membership*

The other item for consideration of the House involves creation of a new membership category. Some component societies have, as a group, elected to terminate membership in the Iowa Medical Society. Under the present Articles of Incorporation and By-Laws there is no mechanism for a physician residing in such a component society to become a direct member of the Iowa Medical Society without convincing his colleagues to again become active members of the Iowa Medical Society. The Committee believes that an "at-large" membership should be created but be available only when a component society has elected as a group not to become members of the Iowa Medical Society.

The Standing Committee on Articles of Incorporation and By-Laws recommends adoption of the following resolutions to create and implement a new category of membership:

Resolved, that Chapter I, Section 1 of the By-Laws be amended to read as follows:

CHAPTER I

Section 1. Membership in the Iowa Medical Society shall consist of Active, Life and Associate Members as defined by Article III of the Articles of Incorporation and also of Resident Physician Members, student members, [and] honorary members *and direct members as defined in Section 10 of this Chapter.* The official roster of members shall be maintained at all times in the office of the Secretary. It shall be composed of the names of those physicians, student members or honorary members certified to the executive office of this Society as provided for by Chapter VI of these By-Laws, and duly approved by the Judicial Council. Registration of the name of a physician, student member or honorary member upon the official roster shall be *prima facie* evidence of his membership and his right to the privileges inherent in that membership.

Resolved, That Chapter I, Section 2 of the By-Laws be amended to read as follows:

CHAPTER I

Section 2. All members of the Iowa Medical Society shall be privileged to attend all sessions of any annual, regular or special meeting except as set forth in Chapter III, Section 2. They may participate in all proceedings except as elsewhere prohibited in the By-Laws. Any active, *direct* or life member shall be eligible to any office within the gift of the Society, providing such member is a citizen of the United States and has been a member of this Society in good standing for [five years] *the two years immediately preceding election.*

Resolved, That Chapter I, Section 3 of the By-Laws be amended to read as follows:

CHAPTER I

Section 3. Except for Honorary *and Direct* members, no person who is under sentence or suspension or expulsion from any component society of this Society, or whose name has been dropped from the component's roll of members for any reason, or who is delinquent in payment of dues to this Society, shall be considered to be in good standing as a member of this Society. No person other than a member of this Society in good standing or an officially registered guest or an Honorary member shall be permitted to take part in any of its proceedings.

Resolved, That Chapter I, Section 4 of the By-Laws be amended to read as follows:

CHAPTER I

Section 4. Each member in attendance at any annual, regular or special meeting shall be registered, indicating either the component Society of which he is a member or that he is an Honorary *or Direct* member. No member shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

Resolved, That Chapter I, Section 6 of the By-Laws be amended to read as follows:

CHAPTER I

Section 6. A member of [a component society] *this* Society who has been convicted of a felony (a plea or verdict of guilty, or a conviction following a plea of *nolo contendere,* is deemed to be a conviction within the meaning of this section), or whose license to practice in this State has been revoked or suspended, shall be dropped from membership in this Society automatically as of the date of conviction, revocation or suspension. He shall be so notified by this Society and of his rights of appeal. A [physician] *member* so dropped from membership may not reapply for membership in this Society until one year has elapsed unless the period of time shall have been shortened by action of the Judicial Council upon appeal by the member.

Resolved, That Chapter I of the By-Laws be amended by inserting the following as Section 10 thereof:

CHAPTER I

Section 10. Direct membership in this Society shall consist of those physicians licensed in Iowa who are either active members in good standing of, or are eligible for such active membership in, a component society which has been suspended in accordance with Section 3 of Chapter VI of these By-Laws, who have been approved by the Judicial Council, and whose regular and special dues for the current year have been accepted at the headquarters of the Society. Direct members shall have the same rights and privileges and pay the same dues as Active members. They shall retain this class of membership only as long as they are not entitled to Active membership.

Resolved, That Chapter II, Section 1 of the By-Laws be amended to read as follows:

CHAPTER II

Section 1. The general meetings of the Society shall be open to all registered members and official guests. Only registered active, *direct,* student and life members may vote on pending questions. Each general meeting shall be presided over by the President. In the President's absence or disability, or upon the President's request, the Vice-President shall perform the duties of president. Before the general meeting, or a meeting of the House of Delegates held at the annual meeting, at such time and place as may have been arranged, the annual addresses of the President, the President-Elect, and other annual orations that have been arranged shall be delivered.

Resolved, That Chapter VI, Section 2 of the By-Laws be amended to read as follows:

CHAPTER VI

Section 2. The annual per capita dues to be charged against the component societies, *and to direct members,* for the general support of this Society shall be fixed by the House of Delegates, the House having first heard the recommendation of the Board of Trustees thereon. The Board of Trustees shall waive dues for residents and for physicians entering military service, and for American physicians located in foreign countries and engaged in medical missionary and similar educational and philanthropic labors, when the component society first waives such dues and requests the Society to do likewise. Annual dues shall be prorated quarterly in the case of new members admitted to the component societies within the calendar year. Per capita special dues against the component societies *and direct members* in lieu of or in addition to annual dues may be fixed at any time by the House of Delegates in the event of financial emergency. The Secretary of each component society shall forward its annual dues, together with its roster of all officers and members,

delegates and alternates, and a list of non-affiliated physicians of the component society's county or district to the Secretary of this Society, on or before January 1 of the calendar year for which the dues have been fixed. The Secretary of each component society shall forward any special dues charged against his society together with a list of all persons having paid the dues, to the Secretary of this Society under such circumstances and within such time limits as may be fixed by the House of Delegates. *Each direct member shall forward his annual dues to the Secretary of the Society, on or before January 1 of the calendar year for which the dues have been fixed. Each direct member shall forward any special dues charged against him to the Secretary of the Society under such circumstances and within such time limit as may be fixed by the House of Delegates.*

Resolved, That the first sentence of Chapter VI, Section 3 be amended to read as follows:

CHAPTER VI

Section 3. Any component society which fails to pay annual dues, or make the reports of delinquent members or such other reports required, *or any Direct Member who fails to pay annual dues, on or before* March 1, shall be held as suspended, and none of *the members or delegates of such component society and no such direct members* shall be permitted to participate in any of the business or proceedings of the Society, or of the House of Delegates, until such requirements have been met.

Resolved, That Chapter IX, Section 4 of the By-Laws be amended to read as follows:

CHAPTER IX

Section 4. Each component society shall judge the qualifications of its own members, but since, *except for direct members,* such societies are the only portals to this Society and to the American Medical Association, every reputable and legally registered physician in Iowa, who is practicing or will agree to practice non-sectarian medicine, shall be considered for membership in accord with Article IV, Section 15, of the Articles of Incorporation.

Resolved, That Chapter IX, Section 8 of the By-Laws be amended to read as follows:

CHAPTER IX

Section 8. A physician living at an inconvenient distance from his component society may hold membership in a more convenient component society, provided no objection is made by the society in whose jurisdiction he resides. If such objection is made in writing to this Society, the Councilor of the District shall endeavor to resolve the problem amicably and in the event of his failure to do so the question shall be referred to the Judicial Council, whose decision shall be final. Subject [only] to the provisions of this section, *and except for direct members,* every physician shall hold his membership in this Society only through the component society holding jurisdiction over the county in which he resides.

Respectfully submitted,
K. J. JUDIESCH, M.D., *Chairman*
J. F. BISHOP, M.D.
R. J. DAWSON, M.D.
P. J. LEEHEY, M.D.
C. R. ROMINGER, M.D.
H. J. SMITH, M.D.

COMMITTEE ON MEDICAL EDUCATION & HOSPITALS

(Referred to the Reference Committee on Miscellaneous Business)

The Committee on Medical Education and Hospitals met late in August, at which time further and continuing consideration was given to the subject of continuing medical education, with special reference to a resolution passed concurrently by the Iowa House of Representatives and Senate during the first session of the 65th Iowa General Assembly. The House/Senate Resolution is as follows:

WHEREAS, Most professions and occupations for which examining boards have been established require the applicant to pass an examination testing his knowledge and skills required for the practice of the profession or occupation; and

WHEREAS, New developments are constantly occurring to change and improve the practice of licensed professions and occupations; and

WHEREAS, Requirements for renewal of a license or registration, except for nursing home administrators and optometrists, merely require filing of the proper form and payment of a renewal fee; and

WHEREAS, The Professional and Occupational Licensing Study Committee, established by the Legislative Council for the 1972 Interim, believes that each person licensed or registered by an examining board should be required to submit evidence of continuing education in order for his license or registration to be renewed, but the Study Committee also believes that each individual examining board can best determine what type of continuing education is most suitable for its occupation or profession, now therefore

Be It Resolved, By the House of Representatives, the Senate concurring, that each examining board be required to submit in writing to the General Assembly, no later than January 14, 1974, its recommendations for continuing education requirements for licensed or registered members of its occupation or profession.

The committee was advised by one of its members who also serves on the State Board of Medical Examiners—Dr. Howard Ellis—that the Board had already discussed the resolution and there was agreement that it should keep in close contact with the IMS and its Committee on Medical Education and Hospitals as recommendations regarding CME requirements are developed.

During discussion of the above resolution, the committee centered its attention on the results of a Random Sample Survey of Continuing Medical Education in Iowa, a project initiated by the committee, and carried out in cooperation with Richard Caplan, M.D., Assistant Dean, Office of Continuing Medical Education, University of Iowa College of Medicine.

The names of 150 Iowa physicians were selected via a computer-generated table of random numbers. The sample size of 150 ensures that a sample percentage will not differ from the true population percentage by more than 8%, 95% of the time. Physicians were guaranteed anonymity in completing the survey questionnaire. Of the 150 physicians selected at random to participate in the project, 13 were found to be no longer engaged in full-time active practice and, therefore, were not contacted. One hundred eight of the 137 distributed questionnaires were returned, giving a response rate of 79%. This response ensures that a sam-

ple percentage will not differ from the true population percentage by more than 9%.

The complete 22-page summary of the survey will be made available to the reference committee which considers this report. The major findings indicate that:

- Physicians are currently devoting an extraordinary amount of time, effort and money in the process of their professional education. The very lowest time spent in all kinds of continuing medical education activities reported by any one physician in the entire sample was slightly more than 100 hours per year, with the overall median approximately 350 hours per year. These numbers fail to reflect time spent at CME meetings and courses sponsored by medical specialty societies.

The time spent in "documentable" CME activity is lower; hence, this demonstrates the importance of admitting a diversity of educational experiences before concluding that a practitioner is not engaged in CME activity.

- 71% of the physicians who took part in the survey expressed the belief that CME as a "requirement" is forthcoming. The majority felt it should be required for (top four listed in order of most frequent responses): a. continued specialty certification (69); b. continued membership in professional associations (64); c. hospital staff appointments (63); d. relicensure by the state (45).
- Major obstacles to more active participation in CME include the "pressures of time" due to patient load and personal factors; CME programs not relevant to problems of practice. (In this regard, the committee acknowledged that quality review programs will be helpful in identifying educational needs of physicians at the local level, so that appropriate educational activities can be implemented.)

After reviewing the resolution passed by the Iowa House and Senate, as well as the results of the Random Sample Survey, the committee agreed on the following points:

- If documentation of CME activities is to become a requirement for physicians, it should be related to relicensure and not to recertification. Recertification should be a function of the various specialty boards.
- Any CME requirements should be broad-based, and there should be provision for a diversity of learning experiences and education.
- Even though evidence of CME does not ensure—or measure—the quality of care rendered by a physician, it does demonstrate to the public that the profession is initiating programs to enhance quality of care.

In addition, the committee unanimously approved the following resolution for submission to and action by this House of Delegates:

WHEREAS, The Iowa House/Senate approved a resolution requiring each examining board to submit recommendations for continuing education requirements for licensed or registered members of its occupation or profession; and

WHEREAS, The State Board of Medical Examiners has requested the IMS to offer its suggestions and counsel with respect to CME requirements for members of the medical profession; therefore be it

Resolved, That the IMS support the concept that evidence of participation in continuing medical education by physicians be established as a requirement for relicensure; and be it further

Resolved, That the details of devising a program for documenting evidence of CME for relicensure be considered jointly by the IMS and the State Board of Medical Examiners.

The House will be interested in knowing that on October 10, Dr. Caplan and I, representing the Committee on Medical Education and Hospitals, met with the Board of Medical Examiners to discuss the House/Senate Resolution and the above resolution approved by the committee. We have been advised that the Board subsequently approved the following motion:

"It is moved, seconded and carried that the Iowa State Board of Medical Examiners feels that documentation of continuing medical education should be a requirement for relicensure; and that the Board should work with the Iowa Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons, and appropriate committees of these societies, to seek enabling legislation dealing with such relicensure."

The Committee on Medical Education and Hospitals has given the matter of continuing medical education considerable study and attention, and it is hopeful the House of Delegates will support its resolution.

Respectfully submitted,
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W. R. BLISS, M.D.
R. M. CAPLAN, M.D.
C. R. EICHER, M.D.
H. G. ELLIS, M.D.
W. C. KEETTEL, M.D.
H. H. KERSTEN, M.D.
R. N. LARIMER, M.D.
L. R. MARTIN, M.D.
R. D. ROWLEY, M.D.

COMMITTEE ON INTERPROFESSIONAL ACTIVITIES

(Referred to the Reference Committee on Miscellaneous Business)

Early in August, the Interprofessional Activities Committee of the Iowa Medical Society met with officials of the Iowa Pharmaceutical Association, the Iowa Society of Osteopathic Physicians and Surgeons, the State Department of Social Services, and Blue Cross/Blue Shield. The purpose of the meeting was to consider a proposed Pilot Pharmacy Project developed by Blue Cross/Blue Shield, which would involve Title XIX beneficiaries, for the purpose of determining whether expanding the pharmacist's role in drug use control can result in added health benefits to the patient, as well as reduce the overall utilization and cost of pharmaceutical services.

In essence, the proposed project calls for increased involvement of the pharmacist in monitoring drug use, and the elimination of the traditional fee for prescription service method of reimbursement by substituting payment on a capitation basis.

The manner in which the project would be implemented is summarized as follows:

1. *Title XIX recipients in two selected counties* (tentatively Marshall and Jasper) would be required to select a pharmacist in the area to provide their pharmaceutical services. The recipient will have freedom to select the pharmacy of his choice and, as nearly as possible, will be restricted to utilizing his selected pharmacy for the duration of the project. However, there will be provision for changing pharmacies and utilizing the services of more than one pharmacy.

2. *Physicians* who participate in the project will be requested to:

a. Provide information to the pharmacist concerning each Title XIX patient's primary diagnosis (those conditions for which drugs are administered) and each patient's drug idiosyncrasies.

b. Review each patient's medication profile with the pharmacist on a monthly basis—e.g., a regular scheduled meeting to discuss each patient's medication history, informal review over the telephone regarding specific problems which might arise, or a monthly review of medication histories provided to him by the pharmacist.

c. Work closely with other physicians and pharmacists in the county to develop drug product selection standards, which would involve a review of selected, widely used, chemically equivalent products in an attempt to select those biologically equivalent or clinically equivalent products which are associated with low cost factors.

3. *Pharmacists* will, among other things, be required to maintain a patient profile record identifying all pertinent factors associated with the utilization and cost of services provided; to monitor each patient's therapy —i.e., an evaluation of each medication with respect to the diagnosis for which it is given, possible interactions with other drugs, adverse drug reactions and drug idiosyncrasies and to take appropriate action when necessary; to work closely with other pharmacists and physicians in the community in the development of drug product selection standards.

Payment will be made to each pharmacy on the basis of $4.50 per eligible recipient per month. If it is demonstrated that the pharmacist's efforts in drug use control bring about a reduction in utilization and, thereby, costs, then additional payments above the $4.50 capitation reimbursement will be made. An escrow account involving 20% of the estimated total drug expenditure in the county for the period of the project will be established, and the funds will be divided among the participating pharmacies and Iowa Department of Social Services at the completion of the project.

4. *The Department of Social Services* will be responsible for providing payment to the Carrier for pharmaceutical services on a monthly basis; providing for coordination by the County Department of Social Services with the administering agency relative to patients' choice of pharmacies, changes in eligibility of Medicaid recipients and changes in provider designation; and with participating pharmacies relative to patient needs and counseling requirements which may become apparent during the course of the project.

5. *Blue Cross,* the Carrier, will be responsible for all activities related to the Pilot Project.

Several points were emphasized to the committee with respect to the proposal:

- The project would not, in any way, alter the privacy of the physician in the treatment of his patient; in fact, its major premise is based on the belief that the physician, as captain of the health care team, can benefit from an improved performance on the part of another member of the team—the pharmacist.
- The development and utilization of product selection standards in no way implies the use of generic products; on the contrary, in light of powerful political forces working toward the institution of state or national formularies based primarily on cost factors, the intent of the proposal is to assure that the selection of a drug product remains in the hands of the physician, who is provided, by the pharmacist, with information on drug product bioavailability and costs, and who makes his own decisions as to which product or products will provide the best results at a lower cost. In illustrating this point, the following example was cited:

The product ampicillin has become the most extensively used systemic antibiotic in this country. About 11% of hospital medical patients generally receive ampicillin therapy and approximately 8 million outpatient prescriptions for ampicillin were dispensed in 1971. Ampicillin is manufactured in the U. S. by eight companies: Beecham-Massengill, Biocraft Laboratories, Inc., Bristol Laboratories, Inc., International Laboratories, Inc., Linden Laboratories, E. R. Squibb and Sons, Inc., Wyeth Laboratories, and Zenith Laboratories. There are 46 companies which supply or package ampicillin products for use in hospitals and pharmacies throughout the country.

A recent bioavailability monograph was prepared based on information received from these firms about their products. The data collected concerned plasma concentration versus time after oral administration of ampicillin to normal subjects. Thirteen of the 46 packagers of ampicillin capsules provided plasma concentration data and 11 of these companies were identified as having acceptable bioavailability with the batches tested. Based on the bioavailability report, the following data has been prepared on the relative drug costs to pharmacies for these 11 drug products.

Manufacturer	*Packager*	*Product Name*	*Cost (10-day Therapy Based on Adult Dosage of 250 mm, 4 Times Daily)*
	Ayerst	Penbritin	4.82
Beecham	Beecham	Totacillin	4.54
Bristol	Bristol	Polycillin	6.06
Beecham	Lederle	Alpen	5.09
Bristol	Parke Davis	Amcill	5.96
International Lab	Reid-Provident	Supen	4.78
Bristol	SKF	SK-Ampicillin	4.80
Squibb	Squibb	Principen	6.00
Bristol	Towne-Paulsen	Ampicillin	3.60
Bristol	Upjohn	Pensyn	4.54
Wyeth	Wyeth	Omnipen	6.38
	Pfizer	Pen A	4.26

With information like this available, it appears that the physicians and the pharmacists operating at the local level can rationally make a choice on which drug product or products could best be utilized for the patient. Allowing the pharmacy to stock and dispense one or two of these many ampicillin products would undoubtedly result in lowered costs to the consumer, and no sacrifice in the quality and the therapeutic benefit to the patient.

• If major goals of the project are achieved—i.e., reducing costs of drug therapy and increasing the involvement of the pharmacist in the "health care team," while at the same time preserving and enhancing quality of care—an attempt would be made to extend the program to other counties, not restricting involvement to Title XIX recipients. If positive results are not obtained, then any effort to expand the program would be abandoned.

Based on the above information presented to and considered by the Committee on Interprofessional Activities, the following recommendation is submitted:

RECOMMENDATION

That the Iowa Medical Society endorse the general concept of the proposed Pilot Pharmacy Project, with the following stipulations: (a) that appropriate modifications and refinements be considered and approved by the Interprofessional Activities Committee of the Iowa Medical Society, representatives of the Iowa Pharmaceutical Association, the Iowa Society of Osteopathic Physicians and Surgeons, and physicians and pharmacists involved at the local level; (b) that if there is not unanimous approval of the proposal by all involved parties after it has been drafted in final form, the project will be abandoned.

The House of Delegates will be interested in knowing that a similar recommendation was presented to and approved by the House of Delegates of the Iowa Pharmaceutical Association last May, and the Iowa Society of Osteopathic Physicians and Surgeons is also scheduled to take action on this matter.

Respectfully submitted,
C. E. RADCLIFFE, M.D., *Chairman*
OSCAR ALDEN, M.D.
V. H. CARSTENSEN, M.D.
S. P. LEINBACH, M.D.
D. A. MATER, M.D.

At this point, Robert D. Whinery, M.D., co-chairman, Iowa Medical Political Action Committee, spoke in behalf of IMPAC and urged physicians to join.

Resolutions

MONTGOMERY COUNTY MEDICAL SOCIETY
NO. 1. STRUCTURE OF IMS HOUSE OF DELEGATES

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The basic components of the Iowa Medical Society are the 92 county medical societies in the State of Iowa; and

WHEREAS, The practice of good quality modern medicine is equally important in both rural and urban areas; and

WHEREAS, The distribution of good physicians is becoming an increasing problem in the State of Iowa as well as the United States; therefore be it

Resolved, That the Iowa Medical Society be enjoined from taking any action to deny the right of any component county medical society to be represented by at least one delegate.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 2. STRUCTURE OF IMS HOUSE OF DELEGATES

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The present apportionment of delegates to the Iowa Medical Society is completely out of balance and representation on an equitable basis no longer exists; and

WHEREAS, Some 20 counties contributing only $150 to $750 to the IMS have the same voting strength as counties contributing up to $5,700. In money and sense the larger county is being made the fool; and

WHEREAS, The state legislature recently underwent re-apportionment and the people of this State are very much aware of equal representation the IMS loses its credibility in speaking for the physicians of Iowa under its present apportionment; and

WHEREAS, Councilor districts, 12 in number, reapportioned in such a manner as to balance each other should not need to fear dominance by any one district; therefore be it

Resolved, That this Society wholeheartedly pass the resolution suggested at the April meeting and realign the councilor districts and elect delegates in that prescribed manner.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 3. STRUCTURE OF IMS HOUSE OF DELEGATES

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The need for reapportionment of the Iowa Medical Society House of Delegates has been demonstrated; and

WHEREAS, Many county societies have shown their desire to retain their component representation in the IMS House of Delegates; therefore be it

Resolved, That reapportionment be on the basis of one (1) delegate from each county society and thereafter for each fifteen (15) members, or major fraction thereof, one (1) additional delegate be granted. (Example: fourteen (14) members one (1) vote, fifteen (15) members two (2) votes, twenty-three (23) members (15+8) three (3) votes, etc.)

WRIGHT COUNTY MEDICAL SOCIETY
NO. 4. STRUCTURE OF IMS HOUSE OF DELEGATES

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The proposed realignment of Councilor districts, described as merely a *suggestion,* would deprive the individual small medical component county societies of their present minimum of one (1) vote in this unicameral legislative body; and

WHEREAS, The Wright County Medical Society would prefer to remain in its present District II (Mason City, the central area of present nine (9) counties) or whatever the District may be called by later; and

WHEREAS, We sympathize with our fellow doctors in the larger counties who feel they are not being represented on a 1 to 1 basis. We agree they should have more representation; and

WHEREAS, We fear that future physicians who might otherwise wish to settle in areas now thinly populated

by physicians might, in turn, be deterred from a defranchised county; therefore be it

Resolved, That:

1. Councilor district component societies remain the same, insofar as each county may wish.

2. Every county continue to have a minimum of one (1) vote in this House, and

3. Change the present ratio of the Delegates from 1 per 25 members to 1 per every 20 members.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 5. IMS FINANCES

(Referred to Reference Committee on Board of Trustees.)

WHEREAS, The Black Hawk County Medical Society has reviewed the "Summary Report of Interim Study Committee on IMS Finances." The County Society approves and endorses the "Committee Recommendations" as outlined in the last paragraph of page one, but the Black Hawk County Medical Society is not in concurrence with proposal number 3, recommending a dues increase be made effective January 1, 1974; therefore be it

Resolved, That a ten member ad hoc committee of the House of Delegates be appointed to meet with the Board of Trustees to select an independent "Management (Business) Consultant" to study structure, function and staffing of the Iowa Medical Society, and be it further;

Resolved, That a change in dues not be considered until the findings, recommendations and conclusions of an independent "Management (Business) Consultant" are reviewed by the House of Delegates at its 1974 Spring Meeting.

DALLAS-GUTHRIE COUNTY MEDICAL SOCIETY
NO. 6. REGULAR MEETING OF IMS

(Referred to Reference Committee on Miscellaneous Business.)

WHEREAS, At the last Annual Meeting of the Iowa Medical Society the Board of Trustees Report stated that the Society . . . *may* schedule a "regular" meeting of the House each Fall, and . . . allow opportunity for action on current issues . . . unless there would be an occasion when there would not be sufficient business to warrant a second session; and further that . . . you can be assured that the Board will devise the most convenient and efficient schedule for conducting the meetings of the House of Delegates; and

WHEREAS, The Reference Committee on Articles of Incorporation and By-Laws were of the opinion that . . . the proposal to make optional the second of the two meetings appears sound in the event *matters of extreme importance* are so few in number they can be held over to the next "Annual" Meeting and recommended: Section 1. The Society shall hold an Annual Meeting in the Spring and *may* hold a regular meeting in the Fall . . . and Article V Section 2 "The Board of Trustees in consultation with the President shall determine whether a regular meeting shall be held; and

WHEREAS, The President, Rubin H. Flocks, M.D., in his official call, stated that "for the first time in its history, the House . . . will hold a Regular Meeting . . . that it is *required* to schedule in accordance with its Articles of Incorporation and By-Laws"; and

WHEREAS, The Interim Study Committee/IMS Finances recommended that expenses be curtailed where possible and appropriate. Therefore, such additional Regular Meetings will double the expenses already budgeted for the Annual Meeting; and

WHEREAS, The additional Regular Meeting will take up another three (3) days, then totalling six (6) days each year, that the Delegates to the House will be required to give in addition to their already overloaded professional obligations; therefore be it

Resolved, That the House of Delegates instruct the President and the Board of Trustees, that as prescribed by the recently changed Articles and By-Laws, that it *shall* hold an Annual Meeting; but that it *may* hold a Regular Meeting only under the most urgent of circumstances and that such business shall be limited to that subject; and that such meeting shall be expedited in a one-day session of the House.

The Speaker announced the meeting places for the various reference committees and advised they would convene at 8:30 a.m., Saturday. Dr. Caraway advised the delegates Dr. Thomas Green, Detroit, a representative of the National Medical Association to the AMA PSRO Advisory Committee and also NMA representative on the National PSRO Advisory Council to the Department of Health, Education and Welfare, would be the guest speaker at the Saturday banquet. The House adjourned at 5:50 p.m.

SUNDAY SESSION, OCTOBER 14, 1973

The Sunday session of the regular meeting of the House of Delegates was called to order at 8:35 a.m. The House approved the taking of attendance by registration cards. There were 86 delegates, 17 voting alternates and 11 ex-officio members present. Delegates' packets were distributed at the time of registration.

COUNTY	DELEGATE
Allamakee	C. R. Rominger*
Appanoose	A. S. Owca
Audubon	H. K. Merselis
Black Hawk	G. R. Clark
	D. E. Conklin
	A. M. Dolan*
Boone	E. E. Linder
Bremer	V. H. Carstensen
Buena Vista	E. C. Laird
Calhoun	R. P. Ferguson
Cass	T. J. Payne
Cerro Gordo	W. V. Wulfekuhler
	R. M. Powell*
	G. H. West, Jr.
Cherokee	G E. Michel
Clarke	J. D. Kimball
Clay	Mary L. Gannon
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Crawford	D. J. Soll
Dallas-Guthrie	E. E. Lister
	W. A. Seidler, Jr.
Davis	J. R. Scheibe*
Decatur-Ringgold	E. E. Gamet
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	L. F. Wallace
Dickinson	D. F. Rodawig, Jr.
Dubuque	J. W. White
Emmet	R. J. Dawson
Floyd	E. E. Schmiedel
Fremont	F. M. Ashler
Greene	E. D. Thompson
Grundy	D. R. Kruschwitz
Hamilton	G. A. Paschal
Hancock-Winnebago	N. D. Thede
Hardin	T. C. Graham
Harrison	J. W. Barnes
Humboldt	J. H. Coddington
Iowa	V. L. Moldenhauer*
Jasper	T. E. Kiernan
Jefferson	W. C. Baumann
Johnson	R. C. Brown
	S. W. Greenwald
	C. E. Radcliffe
	R. D. Whinery
Jones	A. P. Randolph*
Kossuth	M. G. Bourne*
Lee	G. C. McGinnis
Linn	R. A. Sautter
	R. W. Conkling
	R. M. Quetsch
	J. H. Lohnes
	C. A. Hendricks, Jr.*
Mahaska	S. A. Smith
Marion	P. C. Todd
Marshall	W. T. Shultz
	R. R. Widner*
Monona	J. L. Garred
Montgomery	Oscar Alden

COUNTY	DELEGATE
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Page	K. J. Gee
Plymouth	D. K. Faber*
Pocahontas	James Gannon
Polk	John Hess, Jr.
	W. R. Hornaday, Jr.
	C. H. Denser, Jr.
	R. K. Bunten
	D. C. Young
	A. N. Smith
	D. O. Newland
	J. W. Green, Jr.

* Alternate

COUNTY	DELEGATE
	N. K. Rinderknecht
	D. F. Gordon*
	Lester Beachy*
	L. O. Ely*
Pottawattamie-Mills	M. E. Olsen
	Hormoz Rassekh
	A. L. Sciortino
Poweshiek	H. R. Light
Scott	D. A. Bovenmyer
	A. W. Boone
	J. F. Collins
	J. C. Barker*
Shelby	J. H. Spearing
Sioux	E. B. Grossmann, Jr.

COUNTY	DELEGATE
Story	W. R. Bliss
Tama	A. J. Havlik
Union-Taylor	R. H. Kuhl
	R. W. Boulden
Wapello	R. P. Myers
Wayne	K. A. Garber
Webster	D. S. Egbert
	O. N. Glesne*
Winneshiek	T. F. Dynes*
Woodbury	C. T. Helseth
	R. C. Larimer
	D. M. Youngblade*
Worth	B. H. Osten
Wright	C. P. Hawkins

LIAISON DELEGATES

S. P. Leinbach C. W. Seibert

EX-OFFICIO MEMBERS OF THE HOUSE

R. H. Flocks
R. L. Wicks
R. M. Chapman
V. L. Schlaser
J. F. Bishop
J. H. Kelley
L. D. Caraway
L. W. Swanson
H. J. Smith
J. W. Eckstein
J. H. Sunderbruch

Dr. Schlaser read the minutes of the October 12 meeting of the House of Delegates. A motion to approve was passed.

Dr. Caraway expressed his gratitude to the delegates and members of the various reference committees, invited delegates to volunteer for service on reference committees at the next meeting of House of Delegates and asked that inquiries be addressed to the Speaker, IMS Headquarters Office. He then informed the delegates of the proper procedure for debate and voting on Reference Committee Reports.

Reference Committee Reports

The following reference committee reports were acted upon by the House of Delegates.

ARTICLES OF INCORPORATION AND BY-LAWS

(Brackets indicate deletions, italics are additions.)

The Reference Committee on Articles of Incorporation and By-Laws held an open hearing at 8:30 a.m. on Saturday, October 13, to consider the matters assigned. A great deal of interest was demonstrated by the large attendance. There was an open and free debate with participation from physicians representing both urban and rural component societies. The members are to be complimented on the objective and rational discussion. Following are the recommendations which are being suggested by the Reference Committee, based on its evaluation of the testimony, in addition to several "straw votes" on some of the more complicated issues. The items considered by the Committee are as follows:

1. *Report of the Committee on Articles of Incorporation and By-Laws*
2. *Resolution No. 1.* Structure of IMS House of Delegates—Introduced by Montgomery County Medical Society
3. *Resolution No. 2.* Structure of IMS House of Delegates—Introduced by Dubuque County Medical Society
4. *Resolution No. 3.* Structure of IMS House of Delegates—Introduced by Black Hawk County Medical Society
5. *Resolution No. 4.* Structure of IMS House of Delegates—Introduced by Wright County Medical Society

The Committee will deal with each subject contained in the Report of the Reference Committee on Articles of Incorporation and By-Laws separately.

(I.) LIFE MEMBERSHIP

The Reference Committee has reviewed the language drafted by the Standing Committee in line with the resolution passed by the April 1973 House of Delegates and believes it is in order.

RECOMMENDATION: The Reference Committee recommends that the following resolution be adopted:

Resolved, That the first sentence of Article III, Section 3 of the Articles of Incorporation be amended to read as follows:

Article III, Section 3. Any physician who has practiced medicine for fifty years and has been a member of this Society for [thirty] *the last fifteen consecutive* years may be elected to life membership by the House of Delegates, providing his county medical society votes to present his name for such life membership in the Society and providing further that his regular and special dues for the current year have either been accepted at the headquarters of the Society or have been waived by the Judicial Council because of financial hardship.

Mr. Speaker, I move the adoption of the foregoing resolution.

(II.) ELIGIBILITY FOR OFFICE

The Reference Committee finds the recommendations of the Standing Committee to be in order.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolutions:

Resolved, That Article IV, Section 2 of the Articles of Incorporation be amended so that the last sentence thereof shall read as follows:

Article IV, Section 2. * * * These specified officers shall be elected by the House of Delegates on the last day of the annual meeting and eligibility to any office shall include citizenship in the United States of America and membership in good standing in this Society for the [five] *two* years immediately preceding election.

Mr. Speaker, I move the adoption of the foregoing resolution.

Resolved, That Chapter I, Section 2 of the By-Laws be amended so that the last sentence thereof shall read as follows:

Chapter I, Section 2. * * * Any active or life member shall be eligible to any office within the gift of the Society, providing such member is a citizen of the United States and has been a member of this Society in good standing for [five years] *the two years immediately preceding election.*

Mr. Speaker, I move the adoption of the foregoing resolution.

Resolved, That Chapter XIII of the By-Laws be amended to read as follows:

CHAPTER XIII
LIAISON DELEGATES

No later than 15 days prior to the annual meeting of the Nominating Committee, the Liaison Committee shall submit to the Nominating Committee the names of four or more active or life members of this Society in good standing for the preceding [five] *two* years, for the positions of Liaison Delegates. The names so submitted by the Nominating Committee will appear on the lists of candidates for offices and on the printed ballot referred to in Sections 4 and 5 of Chapter IV. From the names so submitted the House of Delegates shall elect two Liaison Delegates to serve as members of the House of Delegates and of the Executive Council as provided in the Articles of Incorporation. Liaison Delegates shall assume office upon adjournment of the annual meeting at which they are elected and shall serve for a term of one year and/or until their successors shall have been elected. A vacancy in the position of Liaison Delegates shall be filled by the Executive Council from nominations submitted by the Liaison Committee, of one or more active or life members of this Society in good standing for the preceding [five] *two* years, to complete the term of the elected Liaison Delegate.

Mr. Speaker, I move the adoption of the foregoing resolution.

(III.) REINSTATEMENT OF MEMBERSHIP

The Reference Committee took note that the AMA has recently amended its By-Laws to eliminate a requirement that a physician who wishes to re-join the society must pay dues for a delinquent year as well as the current year. The Reference Committee believes that the IMS By-Laws should also be amended in this manner.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution:

Resolved, That Chapter VI, Section 3 of the By-Laws be amended to read as follows:

Chapter VI, Section 3. Any component society which fails to pay annual dues, or make the reports of delinquent members or such other reports required, on or before March 1, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Society, or of the House of Delegates, until such requirements have been met. [Suspended members cannot be reinstated until the indebtedness for which they were dropped from the membership roll of the Society has been discharged. Such indebtedness shall apply only to one year of delinquency.]

Mr. Speaker, I move the adoption of the foregoing resolution.

(IV.) DIRECT MEMBERSHIP

The Reference Committee found that the suggested creation of a new membership category to permit "direct membership" in the IMS created a great deal of confusion and misunderstanding in the minds of those in attendance. Discussion of present Articles of Incorporation and By-Laws provisions relating to the status of a "component society" and its charter by the IMS raised many questions which would appear to require some interpretation of the present By-Laws by the Judicial Council. Under the By-Laws, the Judicial Council has the responsibility of interpreting the Articles and By-Laws. Following considerable discussion, it became apparent there is little support for the creation of a new "direct membership" category.

It would appear to the Reference Committee that under the current provisions of the Articles and By-Laws, an individual physician is not prevented from joining the IMS, even though his component society has elected not to support the state organization. In this instance, it is conceivable that one physician could become an officially recognized component society.

RECOMMENDATION: The Reference Committee recommends that the section of the Report on the Committee on Articles of Incorporation and By-Laws relative to direct membership not be adopted.

Mr. Speaker, I move adoption of the foregoing recommendation.

RECOMMENDATION: The Judicial Council be asked to review and interpret the sections of the Articles of Incorporation and By-Laws dealing with component societies, to determine if changes are indicated.

Mr. Speaker, I move the adoption of the foregoing recommendation.

(V.) COUNCILOR DISTRICTS

The Reference Committee believes that the basic interest of physicians relates to reapportionment of the House of Delegates rather than realignment of the councilor districts. The overwhelming majority of those in attendance at the open hearings agreed that councilor districts should remain in their present geographical boundaries. If any specific component society desires to be in another councilor district, a resolution can be presented by that component society to the House of Delegates for consideration.

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolution:

Resolved, That the recommendation of the Committee on Articles of Incorporation and By-Laws pertaining to a possible realignment of the Councilor Districts not be adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

(VI.) REAPPORTIONMENT

The Reference Committee is pleased to note the willingness on the part of the vast majority of those participating in the debate to reach an acceptable compromise which should result in a stronger, more viable, medical organization. The Reference Committee believes this speaks well of the physicians of Iowa, and their interest in preserving a unified medical profession which can best serve the citizens of Iowa through a strong voice, as represented by this House of Delegates. It is obvious that the overwhelming majority of Iowa physicians believe each component medical society should retain its right of representation in the House of Delegates. The Reference Committee supports this concept so obviously endorsed in the Refer-

ence Committee hearings, that each component society should have at least one vote in the House of Delegates. The matter then facing the Reference Committee was to reach a decision which it felt could be accepted by the small rural counties, the medium size counties and the large urban counties. The Reference Committee firmly believes the following proposal would best serve all elements of the medical profession. In essence, the Committee's recommendation merely changes the present formula of one for each 25 members (or major fraction thereof) to one for each 15 members (or major fraction thereof) and retains the right of every component society to be represented in the House by at least one delegate.

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolutions:

Resolved, That Chapter III, Section 3 of the By-Laws be amended to read as follows:

Chapter III, Section 3. Each component society which has made its annual report and paid its dues shall be entitled to send one delegate from each county within the component society to represent it in the House of Delegates of this Society. Each component society which represents an individual county only and which has more than [twenty-five] *fifteen* active or life members in good standing as of the close of the preceding calendar year shall be entitled to send one additional delegate for each such additional [twenty-five] *fifteen* active or life members in good standing (or major fraction thereof). Each component society which represents two or more adjoining counties and which has more than [twenty-five] *fifteen* active or life members in good standing from any county as of the close of the preceding calendar year shall be entitled to send one additional delegate for each such additional [twenty-five] *fifteen* active or life members in good standing (or major fraction thereof) residing in such county. The component society for Student members shall be entitled to send one delegate for each [twenty-five] *fifteen* Student members (or major fraction thereof) in good standing as of the close of the preceding calendar year with the maximum number of delegates set at eight. In case any delegate of any component society is unable to attend any session, his alternate, or any other alternate of said component society designated by the chairman of the delegation, may be seated in his place for the period of said delegate's absence.

Mr. Speaker, I move the adoption of the foregoing resolution.

Resolved, That Chapter IX, Section 10 of the By-Laws be amended to read as follows:

Chapter IX, Section 10. Some time in advance of the annual meeting of the Society each component society which has made its annual report and paid its dues shall be entitled to elect one delegate and one alternate delegate from each county within the component society to represent it in the House of Delegates of this Society. Each component society which represents an individual county only and which has more than [twenty-five] *fifteen* active or life members in good standing as of the close of the preceding calendar year shall be entitled to elect one additional delegate and one alternate delegate for each such additional [twenty-five] *fifteen* active or life members in good standing (or major fraction thereof). Each component society which represents two or more adjoining counties and which has more than [twenty-five] *fifteen* active or life members in good standing from any county as of the close of the preceding calendar year shall be entitled to elect one additional delegate and one alternate delegate for each such additional [twenty-five] *fifteen* active or life members in good standing (or major fraction thereof) residing in such county. The component society for student members shall be entitled to elect one delegate and one alternate delegate for each [twenty-five] *fifteen* student members (or major fraction thereof) in good standing as of the close of the preceding calendar year, with the maximum number of delegates set at eight.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION: Based on the previous recommendation, the Reference Committee believes that the following resolutions should not be adopted:

No. 1. Structure of IMS House of Delegates—Introduced by Montgomery County Medical Society

No. 2. Structure of IMS House of Delegates—Introduced by Dubuque County Medical Society

No. 3. Structure of IMS House of Delegates—Introduced by Black Hawk County Medical Society

No. 4. Structure of IMS House of Delegates—Introduced by Wright County Medical Society

Mr. Speaker, I move the foregoing resolutions Numbers 1, 2, 3, and 4 not be adopted.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws.

Respectfully submitted,
W. R. BLISS, M.D., *Chairman*
J. D. KIMBALL, M.D.
D. F. RODAWIG, JR., M.D.
G. T. SCHMUNK, M.D.
D. C. YOUNG, M.D.

COMMITTEE ON MISCELLANEOUS BUSINESS

The Reference Committee on Miscellaneous Business met in open hearing at 8:35 a.m., on Saturday, October 13, 1973, to consider the four matters assigned to it. The nearly 50 physicians who shared in the four-hour discussion are to be commended for bringing to the Reference Committee much important information and opinion.

Following are recommendations which the Reference Committee has developed based on its evaluation of the matters referred, taking into account the wide-ranging testimony presented during the course of the open hearing.

RESOLUTION NO. 6—INTRODUCED BY DALLAS-GUTHRIE COUNTY MEDICAL SOCIETY REGULAR MEETING OF IOWA MEDICAL SOCIETY

This resolution is interpreted as a call upon the officers of the Iowa Medical Society to keep carefully in mind the new governing language which provides for "regular" as well as "annual" meetings of the House of Delegates. The resolution implores the officers to use the optional mechanism of the "regular" meeting as sparingly as possible and only to resolve the most crucial of Society matters. It also urges institution of a one-day format in view of the heavy work schedules maintained by most physicians.

Inasmuch as the resolution was not received in time to be included in the packets, the Resolved portion is noted here:

"*Resolved,* That the House of Delegates instruct the President and the Board of Trustees, that as prescribed

by the recently changed Articles and By-Laws that it *shall* hold an Annual Meeting; but that it *may* hold a Regular Meeting only under the most urgent of circumstances and that such business shall be limited to that subject; and that such meeting shall be expedited in a one day session of the House."

Testimony was presented by the sponsors and by others which supported the general thrust of the resolution. Reference was also made to the efforts which the officers have exerted to comply (1) with the governing language which declares the "regular" meeting to be optional, and (2) with the need to expedite House sessions to the fullest extent possible.

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution in lieu of Resolution No. 6:

Resolved, That the officers be requested to use their good discretion in evaluating the need for "regular" sessions of the House and restrict the calls for such meetings to times when topics of extreme importance exist; and be it further

Resolved, That the officers evaluate carefully this first "regular" session in terms of attendance, logistics and general delegate reaction when considering the duration of any subsequent "regular" sessions of the House of Delegates.

Mr. Speaker, I move the adoption of this Resolution.

REPORT OF COMMITTEE ON INTERPROFESSIONAL ACTIVITIES

This report requests approval by the Iowa Medical Society of a "Pilot Pharmacy Project." The proposed study emanates from Blue Cross and has received approval from the Iowa Pharmaceutical Association. The study proposes a one-year evaluation of Title XIX patients in two Iowa counties. Under the project, Title XIX recipients would be required to select and utilize the services of one area pharmacist. This pharmacist would then, in direct and frequent consultation with the physician, develop and maintain a comprehensive medication profile for each patient. For this service, the pharmacist would receive a single capitation payment of $4.50 per month.

In the testimony received by the Reference Committee, there was much concern expressed over (1) the questionable and perhaps inappropriate provision that the pharmacist be knowledgeable regarding the patient's primary diagnosis and drug idiosyncrasies, and (2) the need for a monthly review by the pharmacist with the physician of each patient's medication history.

RECOMMENDATION: In reflection of the member reaction to this proposal, as offered at the open hearing, the Reference Committee submits the following resolution:

Resolved, That the Iowa Medical Society underscore its belief that optimal quality health care is made more readily available to all patients, and at the most equitable cost, when active interprofessional communications exist (in this case between physicians and pharmacists), and that this activity should be encouraged at the county and state levels; and be it further

Resolved, That the Pilot Project be referred back to the Committee on Interprofessional Activities with the recommendation that alternate approaches be devised to preserve and enhance the quality of care in this important area while at the same time maintaining surveillance over vital cost factors.*

* *The above* Resolved *was amended to read as follows:* Resolved, *That the Pilot Project be abandoned.*

Mr. Speaker, I move the adoption of this resolution, *as amended.*

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Contained in this report is information regarding passage this year by the Iowa General Assembly of a resolution calling for each state examining board to submit recommendations for continuing education requirements for licensed or registered members of its occupation or profession. A report to the General Assembly on this matter has been requested from the State Board of Medical Examiners by January 14, 1974.

In addition, the Committee report refers to recent action of the Board of Medical Examiners which declares that documentation of continuing medical education should be a requirement for relicensure. In this connection, the Board has indicated a desire to work with the Iowa Medical Society and the Iowa Society of Osteopathic Physicians and Surgeons in developing legislation dealing with such relicensure.

RECOMMENDATION: The Reference Committee has assessed the pro and con testimony offered at the open hearing, and, in light of it and present day circumstances, submits the following substitute resolution:

Resolved, That the importance and value of continuing medical education be totally and forcefully reaffirmed by the Iowa Medical Society; and be it further

Resolved, That the details of devising a program for documenting evidence of continuing medical education be considered jointly by the Iowa Medical Society, by the State Board of Medical Examiners and by the Iowa Society of Osteopathic Physicians and Surgeons; and be it finally

Resolved, That a progress report on the development of such a program be submitted, prior to the consideration of any state legislation, to either this House of Delegates or to the Executive Council.

Mr. Speaker, I move the adoption of this resolution.

REPORT OF COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

This report addresses itself to two important aspects of a complex and important subject area. In its initial section, the report deals with categorization of emergency medical services in the State of Iowa, and it summarizes the work which has been accomplished by the Governor's Advisory Council on Emergency Medical Services.

Witnesses at the open hearing were quick to advance their concerns over the proposed categories and to acknowledge their doubts regarding the possible development of a broadly acceptable classification plan. The words *flexibility* and *simplicity* seemed to appear in most of the suggestions offered for an Iowa categorization listing.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution.

Resolved, That the Iowa Medical Society endorse the concept of categorizing emergency medical service capabilities in Iowa, and be it further

Resolved, That, in view of the expressed uncertainty regarding the classifications submitted, more study be given by the Society, and by the Governor's Advisory Council, to the categorizations, and to the category criteria, with the goal in mind of making them more compatible to Iowa.

Mr. Speaker, I move the adoption of this resolution.

In the second portion of the report attention is directed to possible legislation to permit the certified Mobile Intensive Care Paramedic (MICP) to function. Discussion is offered regarding developments in this area in other states.

RECOMMENDATION: While one speaker at the open hearing spoke in strong opposition to this concept, the Reference Committee recommends the following resolution in the belief it contains proper safeguards.

Resolved, That the Iowa Medical Society support the general concept of authorizing formally trained and certified mobile intensive care personnel to perform certain lifesaving procedures under specified conditions set forth by the medical organization responsible for the ultimate care of the persons involved, and be it further

Resolved, That the Iowa Medical Society Committee on Legislation consider the merits of supporting enabling legislation, including appropriate liability provisions, as well as a provision for the State Department of Health to establish standards and rules, with advice and counsel from an Advisory Council that would include representation from the Iowa Medical Society, and be it finally

Resolved, That if Iowa Medical Society support of such legislation is deemed desirable, the Legislative Committee should consult with the Iowa Heart Association and Iowa State Department of Health in the development of an appropriate bill.

Mr. Speaker, I move the adoption of this resolution.

Mr. Speaker, this concludes the report of the Reference Committee on Miscellaneous Business.

Respectfully submitted,
R. C. BROWN, M.D., *Chairman*
A. W. BOONE, M.D.
R. K. BUNTEN, M.D.
C. T. HELSETH, M.D.
E. C. LAIRD, M.D.

BOARD OF TRUSTEES

At the outset of this report to you, I want to express in behalf of the members of the Board of Trustees our great appreciation to the members of the Interim Study Committee/IMS Finances, and bow to them in deep admiration for their unselfish devotion and tenacity in discharging their assignment. In short, they were tremendous. I am sure you are grateful to them too, and I would like you to tell them so as I ask them to stand—Drs. Newland, Coddington, Dawson, Perry, and Sautter.

This Reference Committee is beholden to those of you who appeared yesterday morning to express your opinions. From these opinions, the committee secured guidance in seeking its conclusions.

You heard Dr. Newland present his committee's report Friday afternoon, and you have had it for your subsequent perusal and digestion. I hope the discomfort of the latter has not been severe and the consumption of Alka-Seltzer not too great.

The Board wishes to base its suggestions to you upon the three recommendations of the Interim Study Committee as printed on page 5 of this report.

The first proposal has to do with the Society's real estate holdings: (a) mortgaging the building to obtain funds; (b) borrowing against fixed assets; and (c) selling the building on a lease-back arrangement.

The very high cost of mortgage money at present would seem to place this in the category of robbing Peter to pay Paul, with Paul rapidly depleting the assets just to keep up with his interest demands. We do not borrow money without committing our fixed assets, this money being needed to complete each year's obligations. Concerning a sales/lease-back arrangement, this will be kept in mind as the Board continues its ongoing examination of the Society's real estate affairs. At the moment the Board feels it should neither mortgage nor sell any of these assets.

RECOMMENDATION: The Reference Committee recommends that the following resolution be adopted:

Resolved, That the Board of Trustees continue to study and evaluate the real estate assets and needs of the Iowa Medical Society, so that appropriate action can be taken if and when it appears to be in the best financial interest of the Society.

Mr. Speaker, I move the adoption of the foregoing resolution.

The second proposal suggests the curtailment of expenses wherever possible. This matter, too, is under constant review. The staff has been able to do much of its own printing and reproductions at a cost much more reasonable than can be done in the commercial market. Your packet folders this year do not have pockets, at a lower price. There are many other comparable efforts made which may seem like peanuts, but add a peanut here and a peanut there, and pretty soon you have a sackful.

I would like for us to consider together, as briefly as we can, the five major categories of expenses listed by the Study Committee on IMS Finances:

1. *Salaries*—The committee pointed out that the percentage of our budget devoted to salaries is below the baseline usually advised for service organizations. Let me emphasize as strongly as I can that our salary schedule and pension plan are inadequate and are not competitive with those of many other medical societies —and certainly not with those in the commercial world. To maintain them where they are is an imposition upon the dedicated and unselfish people who serve us. There is, I think, no room for any reduction in this area.

2. *Physician and Employee Travel*—This item includes out-of-state travel. However, more importantly, it represents the inadequate reimbursement to all those physician members of councils and committees who travel, not only to Des Moines, but wherever else in the state their assignments carry them. They receive 8 cents per mile which, in these days of anti-pollution devices, will barely buy their gasoline. This is also to include any meals not served at the Society's headquarters or during meetings at the Des Moines Club. They are reimbursed in full for hotel rooms.

It was noted on the Study Committee's report that AMA delegates, the AMA alternate delegates, and Board members attending AMA Annual and Clinical sessions receive a certain travel allowance. The committee pointed out that the term was misleading and that the sums of money mentioned were the total expense reimbursements in each instance.

The only manner in which these travel expenses could be reduced would be through reducing the services and activities of the committees within the state and impairing the impact of the IMS upon the national scene.

3. So far as legal and legislative expenses are con-

cerned, the Society's activities in these areas are being re-evaluated. Perhaps if our attacks in the legislative area are conducted with a rifle instead of a shotgun, they may be more effective and less expensive.

4. Under the guidance of M. E. Alberts, M.D., the Scientific Editor, and Don Neumann, the Managing Editor, the IMS JOURNAL has continued to grow in stature as it steadily decreases its deficit. This House has, on numerous occasions, expressed its support of the JOURNAL and has decreed that it shall continue.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That the Board of Trustees and the administrative staff of the Iowa Medical Society continue their efforts to economize and curtail expenses when and where possible, without sacrificing the high standards established for implementing all Society projects and services.

Mr. Speaker, I move the adoption of this Resolution.

Item 3 in the Study Committee's report concerns itself with an appropriate increase in dues. The Board of Trustees is of the opinion that a dues increase of $50.00 per member, per year, is necessary, and will be sufficient to reestablish the Iowa Medical Society on a sound fiscal basis. Any such proposal is always made with reluctance, but there are certain realities which must be confronted.

Dues were last increased in 1969 and long since have the fires of inflation consumed any material gain. We all know that, inflation being what it is, we must run ever faster to stay where we are. If we wish to maintain the prestige and impact of this Society, if we want it to continue its aggressive service to the patients and physicians of Iowa, then we must pay for it.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That the annual membership dues of the Iowa Medical Society be increased from $150.00 to $200.00, effective January 1, 1974.

Mr. Speaker, I move the adoption of this Resolution.

(The motion passed by a majority of 61 votes.)

RESOLUTION NO. 5—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY
IMS FINANCES

"*Resolved,* That a ten member ad hoc committee of the House of Delegates be appointed to meet with the Board of Trustees to select an independent 'Management (Business) Consultant' to study structure, function and staffing of the Iowa Medical Society, and be it further;

"*Resolved,* That a change in dues not be considered until the findings, recommendations and conclusions of an independent 'Management (Business) Consultant' are reviewed by the House of Delegates at its 1974 Spring Meeting."

The Committee hastens to state that it did not, in any way, consider Resolution No. 5 as a reflection upon the integrity of the Board, the staff, or the Interim Study Committee on IMS Finances, and it did not consider the Resolution as a request to audit the books. That possible suspicion disposed of, this committee feels that the intense review and comprehensive report of the Study Committee renders redundant any review by an outside organization at this time. This reference committee, now donning the assorted hats of the Board of Trustees, fervently assures this House that we cannot afford it.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That Resolution No. 5 be not adopted.

Mr. Speaker, I move the adoption of this Resolution.

During the Reference Committee hearings, consideration was given to the desirability of requiring fiscal notes on all resolutions calling for a financial obligation on the part of the Iowa Medical Society. The Board of Trustees feels that such information would be helpful to the delegates as they take action on such matters.

RECOMMENDATION: The Reference Committee recommends that the following Resolution be adopted:

Resolved, That the sponsors of all resolutions introduced to the House of Delegates that would involve an expenditure of funds, include a fiscal note.

Mr. Speaker, I move the adoption of this Resolution.

Whatever your actions, much that is important has transpired here this weekend. It is the business of your constituents back home and they must know of it. We all know the problems of communicating with our membership. People learn things largely through their eyes and ears and if they will not read or listen, the message is lost.

We hope you will do whatever is necessary, up to and including a two by four across the back, to get their attention, and then tell them what you think they should know. Remind them that their medical society is not an adversary which does nothing but demand more money, but it is the servant of the people and the physicians of Iowa.

Tell your colleagues of the good things you do here and encourage them to come and take part in these deliberations. Organized medicine is their only voice loud enough to be heard in the strident babel of modern society.

The Board offers again its thanks to the Interim Study Committee/IMS Finances, and to you, for your time and efforts in these deliberations.

Respectfully submitted,
J. F. BISHOP, M.D., *Chairman*
A. J. HAVLIK, M.D.
JOHN KELLEY, M.D.
R. H. FLOCKS, M.D.
R. L. WICKS, M.D.
R. M. CHAPMAN, M.D.
V. L. SCHLASER, M.D.
T. A. BURCHAM, M.D.

Following recognition of the Board of Trustees, members of Reference Committees, Mr. Donald L. Taylor and IMS staff, the House of Delegates adjourned at 10:30 a.m.

FUTURE SOCIETY DATES

The 1974 Annual Meeting of the Iowa Medical Society House of Delegates is scheduled for May 11-13, 1974 in Des Moines. The 1974 Scientific Sessions will be April 18-20 in Iowa City.

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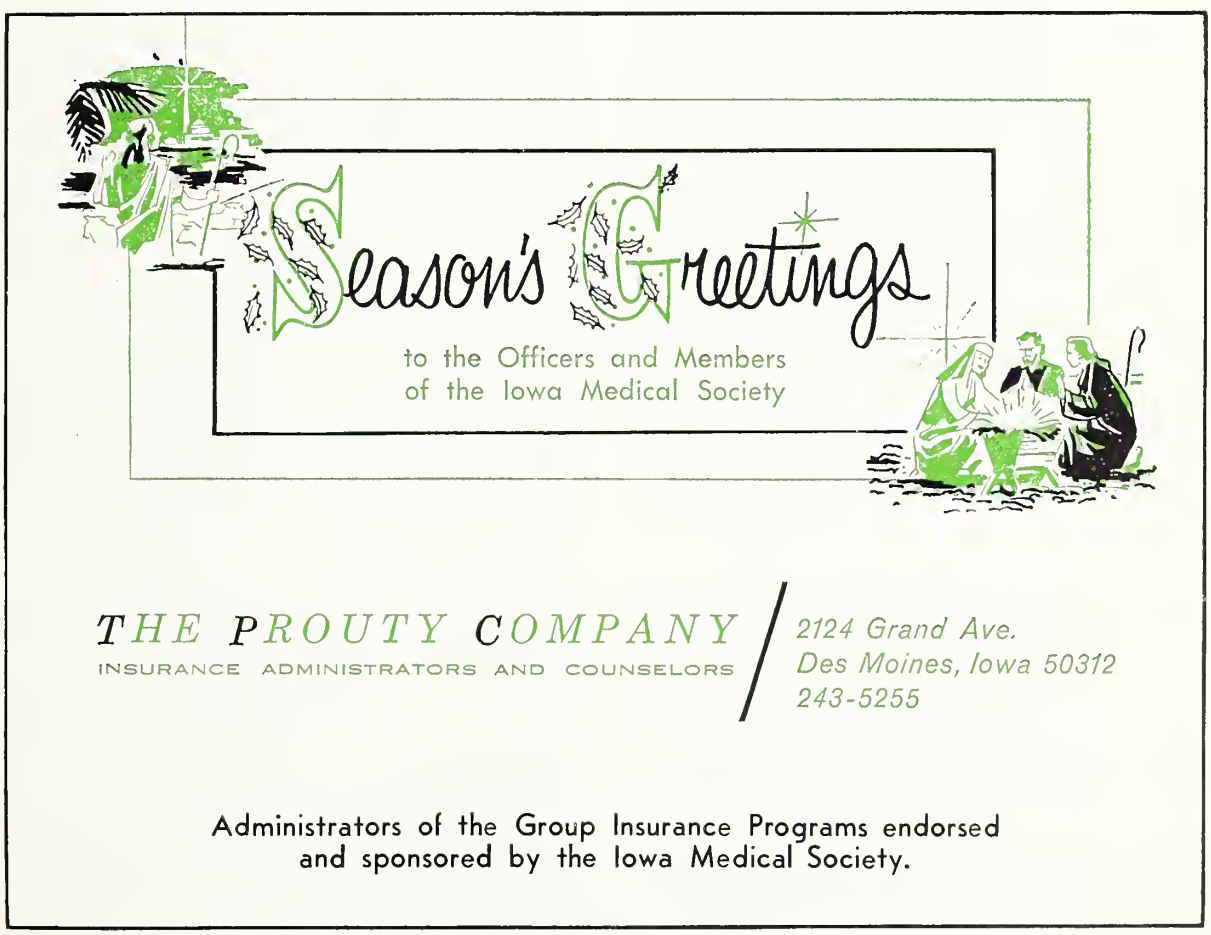
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CHRONIC RENAL DISEASE PROGRAM

The 1972 Legislature passed a bill mandating the Iowa State Department of Health to establish "a program for the care and treatment of persons suffering from chronic renal diseases." The purpose of the program is to "assist persons suffering from chronic renal diseases who require lifesaving care and treatment for such renal disease, but who are unable to pay for such service on a continuing basis."

For the past year the program has been administered by Norman L. Pawlewski, Iowa Commissioner of Public Health, with assistance from Mrs. Gloria Harris, the Commissioner's secretary. Originally $30,000 was appropriated by the Legislature for direct financial medical assistance. An additional $19,000 was transferred to the program from other department funds. The program has had 47 applications for assistance and 32 patients on renal dialysis have been assisted with part of their medical costs.

The law stipulated that a Renal Disease Advisory Committee be created to include representatives of the Kidney Foundation, Iowa Regional Medical Program, Iowa Nurses' Association, Iowa Hospital Association, consumers of health care and two members of the Iowa medical profession involved in renal dialysis and transplantation. This Committee has worked diligently to assist the Department in discharging its duties.

The program does not deliver direct health care to patients, but assists them financially after all other sources of financial assistance have been utilized. The Department and the Committee have established financial criteria and medical review procedures.

This fiscal year's appropriation has been increased by the Legislature to $208,030. Of this appropriation, $200,000 is budgeted for direct medical assistance for dialysis and transplant patients. To date, 30 patients have received financial assistance from the current fiscal year appropriation. It has been projected 75 new patients will be diagnosed each year as suffering from renal faliure and will require dialysis and transplants.

Anyone may qualify and receive assistance from the program due to the very high costs incurred. Inquiries or requests for application forms should be directed to Mr. Juris Poncius, the Program Director, or to Gloria Harris.

It is the hope of the Department that with Medicare expansion and with the Chronic Renal Disease Program, no individual in the State will suffer financial collapse due to their end stage renal failure.

Rh IMMUNE GLOBULIN

Prevention of erythroblastosis fetalis, or Rh-hemolytic disease of the newborn, is now possible with the development of Rh immune globulin* (RhIG), licensed in 1968. RhIG suppresses the immune response and thus can prevent formation of Rh antibiodies in Rh-negative patients. Routine use of RhIG for Rh-negative women who give birth to Rh-positive infants or who undergo abortion should eliminate erythroblastosis.

ERYTHROBLASTOSIS FETALIS

Erythroblastosis fetalis was first described in 1932, with the realization that four perinatal diseases—late fetal death with erythroblastosis,

* Official name: Rh_o(D) Immune Globulin (Human). This discussion constitutes the recommendation of the Public Health Service Advisory Committee on Immunization Practices.

hydrops fetalis, icterus gravis neonatorum, and congenital anemia of the newborn—were part of the same pathologic process. Discovery of the Rh factor and the understanding of Rh immunology led to the elucidation of pathogenesis of the disease 9 years later. It was shown that Rh antibodies result from exposure of an Rh-negative woman to Rh-positive fetal red blood cells which pass through the placenta (transplacental hemorrhage) into the maternal circulation during labor, delivery, or abortion. In a subsequent pregnancy with an Rh-positive fetus, the anamnestic response results in further elaboration of these antibodies which then transfer across the placenta into the fetus where they cause hemolysis of Rh-positive fetal red blood cells.

In the United States, 15 per cent of whites and 5 per cent of blacks are Rh-negative. About 8 per cent of all pregnancies (9 per cent of white women and 4.5 per cent of black women) are complicated by Rh incompatibility—an Rh-negative woman with an Rh-positive fetus. The severity of erythroblastosis in affected infants can vary from only a positive Coombs test to stillbirth with hydrops. Each year over 20,000 affected infants are born and about 5,000 pregnancies end in stillbirth due to Rh-hemolytic disease. The neonatal case fatality ratio is less than 5 per cent when exchange transfusion is used. Nevertheless, a small percentage of affected infants still develop kernicterus.

Rh IMMUNE GLOBULIN

RhIG is a sterile solution of gamma globulin (10-18 per cent globulins) prepared by cold alcohol fractionation from plasma of donors with high Rh antibody titers. Each dose of 1-1.5 ml injected intramuscularly contains at least 300 micrograms of Rh IgG. In worldwide clinical trials, 98.8 per cent of RhIG recipients did not develop Rh antibodies in a subsequent Rh-positive pregnancy; 11.4 per cent of controls did. Immune suppression is transient, however, and a dose of RhIG may be required for Rh-negative women after each birth or abortion.

RhIG USAGE

RhIG is recommended for Rh-negative women at risk of developing Rh antibodies. Any Rh-negative woman whose serum does not contain Rh antibodies and who is exposed to the Rh antigen via delivery of an Rh-positive infant or an abortion should be given 1 intramuscular dose of RhIG within 72 hours after delivery or abortion.* (A crossmatch between RhIG and maternal red blood cells, described in the manufacturers' directions for use, may be of value in detecting a large transplacental feto-maternal hemorrhage.)

Although ABO blood group incompatibility between the Rh-negative mother and her Rh-positive fetus may provide partial protection against developing Rh antibodies, RhIG should be given in all such cases for optimal prophylaxis.

ABORTION

Transplacental hemorrhage occurs in spontaneous and induced abortions, although in lesser amounts than in full-term deliveries. The risk of developing Rh antibodies increases with the length of gestation; the risk is also higher with abortion by amnioinfusion of hypertonic saline or hysterotomy than by dilatation and curettage. Since the Rh characteristic of the fetus is unknown, all Rh-negative women undergoing abortion should receive RhIG unless they are already known to have Rh antibodies or unless the father is Rh-negative.

TRANSFUSION WITH Rh-POSITIVE BLOOD

The use of RhIG in an Rh-negative person who inadvertently receives a transfusion of Rh-positive blood is under investigation. It is not recommended routinely. Doses of RhIG ranging from 10-30 micrograms for each milliliter of Rh-positive blood transfused have been shown to be successful in preventing development of Rh antibodies. If used, attendant patient care, requires careful monitoring for hyperbilirubinemia, blood hemoglobin concentration, and renal function.

REACTIONS

Reactions in RhIG recipients are infrequent, consisting of slight soreness at the site of injection and/or slight temperature elevation.

PRECAUTIONS AND CONTRAINDICATIONS

RhIG should be given only to a woman postpartum or post-abortion. It should not be given to an infant or father.

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* An Rh-negative woman who is D^u (Rh_o [D] factor variant) positive on more refined testing is not at risk of developing Rh antibodies and does not need RhIG.

RhIG is not useful in a patient who already has Rh antibodies.

RhIG should not be given intravenously.

RhIG is not indicated in an Rh-positive (or D^u-positive) person.

SURVEILLANCE

Careful surveillance of Rh-hemolytic disease and patterns of RhIG use is necessary to monitor the benefits of RhIG prophylaxis. In addition to observing the general incidence of affected pregnancies, the specific occurrence of (1) liveborn infants with hemolytic disease, (2) infant deaths due to erythroblastosis, and (3) stillbirths due to Rh incompatibility should be determined.

Published MMWR: Vol. 21, No. 15, 1972; reprinted Vol. 21, No. 25—Supp, 1972.

Morbidity Report for October, 1973

Disease	Oct. 1973	1973 to Date	1972 to Date	Most October Cases Reported From These Counties
Amebiasis	2	77		Guthrie, Muscatine
Brucellosis	1	5	24	Linn
California virus infection	1	1		Dubuque
Chickenpox	303	11150	6450	Buena Vista, Floyd, Scott
Conjunctivitis	45	886	643	Bremer, Winnebago
Coxsackie B-3 infection	3	4		Polk
Eaton's Agent infection	3	18		Boone, Polk, Wapello
ECHO 6 virus infection	1	1		Johnson
Encephalitis, assoc. w/ECHO 6	1	2		Buchanan
Encephalitis, type unspecified	2	15	2	Johnson, Lyon
Encephalitis, viral	1	8	6	Polk
Encephalomyelitis, type unspecified	1	1		Hamilton
Endolimax nana infection	1	3		Johnson
Erythema infectiosum	2	1342		Monroe
Filariasis	1	1		Black Hawk
Gastrointestinal viral infection	417	6020	4274	Jackson, Johnson, Marion
Giardiasis	3	17		Humbolt, Webster
Hepatitis, infectious	4	171	203	Scattered
Hepatitis, serum	3	43	43	Dallas, Polk, Warren
Hepatitis, type unspecified	1	19		Marion
Herpes simplex	10	59		Johnson, Warren, Worth
Herpes zoster	3	18		Cedar, Johnson, Poweshiek
Hymenolipis diminuta	1	1		Iowa
Impetigo	68	350	227	Scattered
Infectious mononucleosis	85	607	594	Scattered
Influenza-like illness	612	12422		Johnson, Linn, Polk, Warren
Meningitis, aseptic or viral	5	14	6	Scattered
Meningitis, bacterial	1	5	3	Polk
Meningitis, aseptic assoc. w/ECHO 4	1	1		Marion
Meningitis, cryptococcal	1	1		Washington
Meningitis, pneumococcal	1	4		Clay
Meningitis, strepto-vinders	1	1		Tama
Meningitis, type unspecified	2	28	14	Linn, Story
Meningococcal meningitis	2	20		Des Moines, Story
Meningoencephalitis, assoc. w/ECHO 6	1	1		Johnson
Meningoencephalitis	1	9		Muscatine
Mumps	138	3238	5677	Scattered
Pediculosis	35	165		Decatur, Fayette, Lee
Pinworms	5	11		Johnson, Marshall, Polk
Pneumonia	84	953	599	Scattered
Rabies in animals	12	196	274	Scattered
Ringworm, body	27	122		Scattered
Ringworm, scalp	1	4		Warren
Roseola	1	4	6	Butler
Rubella	12	216	384	Scattered
Rubeola	2	280	716	Buena Vista, Dickinson
Salmonellosis	39	177	102	Scattered
Shigellosis	23	258	200	Scattered
Scabies	7	20		Johnson, Scott
Streptococcal infections	500	5618	4826	Scattered
Tuberculosis, active	10	109	76	Scattered
Venereal diseases:				
Gonorrhea	545	5219	4062	Polk, Scott, Woodbury
Syphilis	36	360	337	Scattered

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A PERSONAL PERSPECTIVE AT YEAR'S END

THIS'LL BE A LITTLE DIFFERENT. Usually, we write in this spot about PSROs, Medicare, health care legislation, etc. Important topics, to be sure. Most worthy of serious reflection and thoughtful comment.

But this month—fittingly December (when love, compassion and kindness take an upswing)—we'd like to talk about physicians.

We take a calculated risk. When you write about your employers (as is the case here) your words understandably become suspect. Too much saccharin jeopardizes believability. Contrastingly, undue criticism may speed your departure.

What prompts these comments? Personal involvement. In the past month, two trying episodes—one ending in death and one more routine—have caused a personal reaffirmation of faith in the medical profession. Those who ministered to health care needs in these instances did so with willingness, dedication and skill. The efforts of these physicians were extraordinary and deeply appreciated by those concerned.

Casual impressions and comments influence the thinking of any person on almost any subject. But first-hand, personal involvement strikes home with the greatest meaning. To observe conscientious near-midnight diagnostic efforts followed by extended, early-morning surgery can't help but comfort and support the ill and those who stand by them.

This schedule for physicians is repeated day-in and day-out. They assume maximum responsibility and carry it out, in the recent observation of this writer, with all the technical competence and compassion at their command. For most, hopefully, the illness will be brief and not return for a reasonable time interval. But it's part of the daily routine for most physicians, a routine drastically different from what most of us know.

It becomes quickly apparent that the physician has many hats to wear, many roles to assume, each of which seems to require unique traits, qualities and prerequisites. Obviously, some physicians have greater strength in one area, less in another.

The physicians we've confronted personally under trying conditions in days just past have functioned as counselors, as listeners, as scientists, as interpreters, as diagnosticians, as surgeons. Their performances in each of these roles have been admirable.

Care of the sick has been described variously. Hippocrates is quoted: *Wherever the art of medicine is loved, there also is love of humanity.* Sir William Osler said: *And from the standpoint of medicine as an art for the prevention and cure of disease, the man who translates the hieroglyphics of science into the plain language of healing is certainly the more useful.*

The science of medicine changes and progresses. For this we are grateful. However, people remain much the same. As patients, and as families, we still have fears. We know inevitably physicians must deal with our fears as well as with our physical ailments. It's trust, confidence and respect that we seek in such dealings.

Robert Louis Stevenson once wrote: *There are men and classes of men that stand above the common herd . . . the physician almost as a rule. He is the flower (such as it is) of our civilization. . . . Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage.*

Forgive the personal references contained here. They simply constitute an indirect expression of gratitude to a select group of physicians—their efforts reflect most favorably on the profession of which they are a part.—DN

IN THE PUBLIC INTEREST

LAUDS HOUSE ACTION

Soon after the meeting of the House of Delegates, Mrs. Wicks and I left the country for a few days in the Orient. This is a long, long trip and we find these old bodies do not adjust to the time change as well as in younger days. After 48 hours in Tokyo, the brain begins to function and some reflections on the recent House actions are in my thoughts.

The actions included a substantial dues increase and a compromise reapportionment of the House to give the more populated counties better representation while still allowing at least one vote to each component society.

Your officers appreciate the "vote of confidence" and will increase efforts to maintain the service to members which such confidence deserves. So many projects require the attention of the Society that it is sometimes difficult to rate them in order of their importance. The staff is on constant alert to all developments which affect the profession and the health problems of the people of the State.

So, the democratic process has worked, not to everyone's satisfaction, but it is hoped that all members will accept the decisions and continue their support for the benefit of the entire organization.

Much debate took place in the reference committee hearings and on the floor of the House. Such discussions are the best way to settle differences. There is no place in these discussions for severe reflections on others and debasing references to individuals with principles with which we disagree. We can settle our differences and come to conclusions as gentlemen.—RALPH L. WICKS, M.D., *President-elect, Iowa Medical Society*

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